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Three Theoretical Frameworks for Grief Counseling of a Bereaved Spouse: Psychoanalytic, Humanistic, and Behavioristic

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THREE THEORETICAL FRAMEWORKS FOR GRIEF COUNSELING OF A BEREAVED SPOUSE: PSYCHOANALYTIC, HUMANISTIC, AND BEHAVIORISTIC

by

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VITA

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CHAPTER I

INTRODUCTION

Purpose of the Study

During their lifetime, many people experience the death of a spouse. Following the death, the surviving partner is forced to make emotional and behavioral changes to adjust to a new way of life as a widow or widower. This adjustment is accomplished through the process of grieving. Occasionally people experience difficulty with the changes forced upon them in conjugal bereavement and they seek the help of a counselor. The purpose of this dissertation is to examine, by means of historical research, how the psychoanalytic, the humanistic, and the behavioristic theories of counseling have been applied to the treatment of the grieving spouse.

During the last fifty years, societal changes in American life have made grieving more difficult. These changes include: lack of extended family, overexposure to violence through the media and the threat of war, and a lack of participation by the bereaved in the death of a loved one and in funeral preparations.

At the turn of the century Freud (1917/1957) described mourning as a normal process which should not be

treated with psychoanalysis unless a pathological reaction developed. In fact, intervention by the therapist during mourning could be harmful. Freud thought that it was the family who should support the bereaved. Unfortunately, during the last several years, the extended family often is no longer present to help the widow or widower. So, conjugal bereavement frequently means an adjustment to living alone during a time when emotional support is needed most. Because talking repeatedly about the circumstances of the death and reminiscing about the deceased are normal parts of grieving, the spouses who are left alone are hindered in their ability to express their grief.

Overexposure to death and violence is creating an unusual double standard which Gorer (1976) calls the "pornography of death." On one hand, Americans are flooded with stories on television, on the radio, and in the newspapers of violence and tragedy. Yet, until recent years, serious literature on death was considered as outcast a topic as sexual pornography (Jackson, 1957; Gorer, 1976). The real pornography of death including war stories, westerns, and horror comics is allowed to survive. "It seems symptomatic that the contemporary sect of the Christian Science should deny the fact of physical death, even to the extent (so it is said) of refusing to allow the word to be printed in the Christian Science Monitor" (Gorer, 1976, p. 75).

Another aspect of our overexposure to death comes from the threat of war.

> We live in a paradoxical century. On one hand there has been more killing by the state than ever before; over 110 million deaths since 1900 in brutish wars, deliberate famines, planned starvations, police and government executions...; on the other hand, there has been no century where so much effort has been put into increasing the general life span (Shneidman, 1976, p. xx).

People are confused by this double standard. How can a nation build bombs capable of destroying millions while spending equal amounts of money developing new apparatus to prolong life?

The threat of nuclear war is changing the way people view the meaning of life. Lifton (1967) studied Hiroshima survivors 20 years later and found definite changes in how they found meaning in life. We all have a need to maintain a sense of immortality in the face of biological death (Toynbee, 1963, 1976; Lifton, 1967; Shneidman, 1976). Before the bomb was dropped on Hiroshima, the survivors believed that they would have immortality through their children, through release to a higher form of life, or through their creative works. After the bomb, these three ways of achieving immortality became meaningless. More specifically, they could not live through their children because the children died too in the blast or later of related diseases. The Japanese also found it difficult to believe in a higher form of life in the face of what they saw as evil destruction. Finally, being immortalized

through art or literature is meaningless because it was all destroyed.

The Japanese in this study (Lifton, 1967) experienced an intellectual shift in order to retain the idea of their own immortality--the concept of living through nature. They came to view immortality in terms of the universal psychic imagery in which nature represents an ultimate aspect of existence. In other words, the mountains and rivers survived the mass destruction and the Japanese came to believe that they could live on through these natural structures.

Existential confusion concerning the meaning of life and death such as the Japanese experienced after the nuclear destruction is typical of what all humanity, having to live with the threat of nuclear destruction, now faces. Grieving was formerly a process following a natural death. Now some of the naturalness of death has been replaced by threats of mass annihilation. According to Albert Camus, "The 17th century was the century of mathematics, the 18th that of physical sciences, and the 19th that of biology. Our 20th century is the century of fear" (cited in Shneidman, 1976, p. 49).

A third change which has made grieving more difficult within the last years is the lack of participation by the bereaved in the death and the funeral preparation of their loved ones. Until recently, ill people were allowed

to stay in their own homes with their families until they died. Today most people die in hospitals away from their loved ones. Often lives are prolonged with life support equipment even when the person wishes to be allowed to die. A hopeful trend away from this institutionalizing of death is the hospice movement (Feifel, 1969; Stoddard, 1980).

Funeral preparations were formerly made by the grieving family. They were able to make the coffin, prepare the body for burial, and actually bury the body. This participation helped to make real the death and to begin the grieving process. In other words, there was little time for denial. Today, however, funeral directors take over many of these tasks. Embalming tries to mask death and the condition of physical death is not recognized (Philippe, 1976; Baird, 1976). Funeral directors have become "doctors of grief" whose role it is to help people through an "unnatural" time as quickly and as painlessly as possible.

There is physical evidence that people in our culture are not grieving in a healthy manner. Research shows that people in mourning have a high rate of physical (often psychosomatic) illness. Erick Lindemann (1944) found that 33 of 41 patients with ulcerated colons developed the disease very soon after the loss of a loved one. E. Weaver Johnson (Jackson, 1957) found a close relationship between diabetes and unresolved grief. Additionally, statistics have shown the onset of cancer most often follows the loss

of a loved one through divorce or disease (Shealy, 1977; Parkes, 1969, 1970).

In short, changes during the last fifty years such as lack of family support in mourning, overexposure to death and violence, and lack of participation in dying and the funeral arrangements have made grieving more difficult. The grieving process which was formerly viewed as a normal phenomenon has become an unnatural and fearful experience. Because of these changes, counselors are having to deal with the problems of unresolved grief more frequently than in Freud's time (Shneidman, 1976). "Modern man does not know how to proceed in the fundamental expressions of grief" (Jackson, 1957, p. 57).

Procedure

The question then becomes, "How does the counselor treat the bereaved client?" Obviously counselors vary in their views of the nature of man, in their analysis of problems, in their goals, in their process of treatment and in their techniques (Woodworth, 1964; Patterson, 1966). In general, three theoretical approaches to counseling have emerged; the psychoanalytic approach, the behavioristic approach, and the humanistic approach (Buehler, 1967; Maslow, 1968). Most counselors subscribed to one of these theories or a combination thereof. Therefore, by examining the literature of these three theoretical approaches data meaningful to all counselors can be obtained. The intent of

this investigation is to determine what work has been done by theorists in each of the these three frameworks to help the grieving client.

It is not the goal of this dissertation to explain the fundamentals of these three approaches to counseling. An assumption has been made that the reader has a working knowledge of these theories. Rather, this dissertation is limited to a discussion of these theories as they specifically pertain to the grieving spouse. Although many types of loss exist, for the purpose of limitation, this dissertation deals only with conjugal bereavement, the death of a spouse.

The analysis of each theory includes the developmental overview of the theory and review of the existing literature, a description of the mourning process, the goals of the therapist, the process of treatment, techniques of the therapist, and criticism of the currently used therapeutic process. A brief explanation of each of these topics will now be offered.

The overview of the development of the theory and review of the literature section answers the following questions: Who were the originators of the theory? How did one theorist build on the works of another? This section also emphasizes the idea that no thought has a given starting point since all men build on the ideas of their ancestors. Yet, certain men are able to establish new paradigms

in scientific thought and they provide milestones for further intellectual growth (Kuhn, 1970).

The review of existing literature is based on the original grief related works of the main proponents of the three theoretical frameworks. The psychoanalytic section is founded in the writings of Freud, Lindemann, Bowlby, Parkes, and Marris. The behavioristic section refers to the works of Skinner, Ramsay, and Beck. The humanistic section is grounded in the writings of Maslow, Rogers, May and Frankl. All of the above mentioned theorists were chosen because of their specific contributions to grief literature with three exceptions: Skinner, Maslow, and Rogers. Skinner is included, although he makes few references to grief, because understanding his thought forms the basis upon which Ramsay and Beck base their grief counseling theory. Similarly, Maslow and Rogers did not address themselves at length to the problems of grieving people, but their contributions to the field of humanistic counseling are transferable to the grieving client.

Marris is included with the psychoanalytic theorists although he is not necessarily psychoanalytic. His works have been included because Bowlby uses them as a starting point for his description of the spouse who is grieving normally. Bowlby has done most of his grief research on persons who were grieving in a pathological manner and he needed a model for normal grief.

The next section provides a description of the mourning process. The problems initiated by the death of a spouse include such things as guilt, anger, loneliness, depression, somatic distress, attempts to avoid reality, and disorganization (Lindemann, 1944). Each theoretical framework offers a different explanation for the etiology and the perpetuation of these problems. This dissertation reviews these varying psychologies of the grieving process because how a problem is perceived affects how it will be treated. This section answers the questions: What are the characteristics of the grieving spouse? Do these characteristics appear in stages? How long does the grieving process last? What is the difference between normal and abnormal grief? Is grief an illness?

Once therapists have defined a problem, such as describing what process the bereaved is experiencing, they are able to set treatment goals. Of course, these goals may vary depending on one's philosophy of grieving. Examples of treatment goals include helping the bereaved (1) to separate themselves from the deceased by breaking the bonds between them, (2) to readjust to their new environments, and (3) to form new relationships (Bowlby, 1960; Gorer, 1965; Lindemann, 1944).

The "process of counseling" section answers the following questions for each of the three theoretical frameworks: (1) When does the grieving person need counseling?

(2) How is the relationship developed with the client? (3) How is information about the client gathered? (4) How does the grieving person gain insight into his/her behavior? (5) How does reorientation occur so that the client is able to choose a different way for the future?

The techniques of counseling are very specific tools which a counselor may use to facilitate the counseling process. These may include for example, mirror techniques, problem solving, assertiveness training, or dream analysis.

The section on criticism of each of the three theoretical views of grief counseling highlights the strengths and weaknesses of each of the presented viewpoints. This section will deal with the criticism of psychoanalytic, behavioristic, and humanistic theory only as they relate to the grieving client.

Chapter V outlines patterns (Barzun, 1970), ways in which authors have similar ideas about the meaning of life, the process of grieving, and the counseling procedures which could help the bereaved client.

In general, this dissertation provides a systematic account, both topical and chronological, of the development of theoretical frameworks for counseling the bereaved client.

Criteria for categorizing authors as psychoanalytic, humanistic, or behavioristic

A crucial part of this dissertation is the assignment of authors into the most appropriate school of thought--psychoanalytic, humanistic, or behavioristic. The chosen theorists were reviewed with the following criteria in mind:

1. What principles of human behavior do they espouse?
2. What vocabulary do they use?
3. When other writers speak of the theorist in question do they classify him as psychoanalytic, behavioristic, or humanistic? How do these chosen theorists categorize themselves?

These criteria will now be discussed in turn.

1. What principles of human behavior do they espouse?

Members of the psychoanalytic school generally agree on the following points:

a) psychological determinism--most behavior is not accidental;
b) the importance of the unconscious process in determining behavior;
c) the categories of human functioning--the id, the ego, and the super-ego;
d) genetic approach--importance of early childhood development

(Levitt, 1959; Patterson, 1966; Munroe, 1969).

According to Maslow (1968), those categorized as humanists generally agree on the following points:

a) Each person has a biological inner nature which is unchangeable due to heredity.

b) This inner nature of each person is, in part, unique and in part the same as other people (Child, 1973).

c) This common part of human nature can be studied scientifically.

d) Basic human emotions are either neutral, pre-moral, or good.

e) This inner nature should be allowed to guide our lives since it is either good or neutral.

f) If this inner core is suppressed, the person becomes sick.

g) This inner nature is weak and can be overcome by habit, cultural pressure, and the wrong attitude about it.

h) This inner self never goes away, but continues to press for actualization.

i) Discipline, deprivation, frustration, pain and tragedy are necessary because they reveal and foster our inner natures. These experiences increase self-esteem and self-confidence. People who have not conquered tragedy become

> fearful that they could not cope with difficulty. This is not only true of dangers from the outside, but from internal impulses as well.

Despite the many diverse approaches of behavior therapists, general characteristics of behavior therapy treatment can be discerned (Kazdin, 1978; Kazdin & Herson, 1981). Kazdin (1978) lists these characteristics as follows:

a) focus on current rather than on historical determinants of behavior;

b) focus on observable behavioral change as a means of evaluating treatment;

c) specification of treatment in objective terms so that it can be replicated;

d) therapeutic techniques are based in research in psychology;

e) specific measurements are taken during treatment and after to measure improvement in objective terms.

In 1981, Kazdin omitted one of the five characteristics of behavior therapy as stated in 1978, the idea that all therapeutic techniques are based upon research in psychology.

For the purpose of this dissertation, authors will be categorized on the basis of which group of the above

assumptions seems most compatible with their theoretical positions. This can be discerned by reading their original works.

2. What vocabulary is specific to each theory?

Vocabulary of the psychoanalytic school includes terms such as: id, ego, super-ego, the unconscious, Oedipal attachments, defense mechanisms, free association, death instinct, libido, projection, repression, displacement and narcissism. Other psychoanalytic terms are: transference, castration complex, separation anxiety, and infantile sexuality (Strachey, 1964).

Humanistic psychology stands for respect and openness to all people and to any method of treatment which proves helpful to clients. Vocabulary and topics common to humanistic writing include, "love, creativity, self, growth, organism, basic need-gratification, self-actualization, higher values, being, becoming, spontaneity,...peak experiences, courage, and related concepts" (from Articles of the American Association of Humanistic Psychology in Severin, 1965, p. xvi).

The vocabulary of behaviorism includes such terms as: stimulus, response, positive reinforcement, negative reinforcement, trial-and-error, extinction, delayed responses, conditioned responses, conditioning, functional relationships, and differential effects. Other common terms are primary and secondary reinforcement, conditioned

behavior, conditioning of inhibition, systematic behavior development, and behavior chains (Franks, 1969).

Although authors may use terms from all three of these groups, generally the vast majority of their vocabulary comes from a specific theoretic orientation. By using this vocabulary as clues, it is possible to make an educated assumption as to whether an author is psychoanalytic, behavioristic or humanistic.

For example, the following paragraph is taken from Bowlby's most recent book on loss:

> A second usage rejects any linkage to cognitive psychology and reserves the term to denote "the child's capacity to keep up object cathexis irrespective of frustration or satisfaction", a phase postulated to be contrasted sharply with a previous phase during which a child is held to consider the object as "non-existent, unnecessary" whenever "no need or libidinal wish is present..." (A. Freud 1968). This usage is in keeping with Hartmann's original proposal and is adopted by Anna Freud and those influenced by her. (Bowlby, 1980, p. 431).

In this passage, several key words suggest that Bowlby expounds the psychoanalytic theory. "Object cathexis" is a term first used by Freud (1933/1964) to express the idea of physical energy being invested or attached to an object. Object cathexis comes from instinctual drives originating in the id (Fodor, 1969). Also, the term "libidinal", another word originating with Freud (1913/1955, 1916/1957), is used by Bowlby.

Other clues from this paragraph as to Bowlby's philosophy of counseling are his references to two other

psychoanalytic writers, Hartmann and A. Freud. In the bibliography to Loss, Bowlby cites two articles by Hartmann. Both of these articles appeared in the Psycho-analytic Study of the Child and were originally published in a book by Hartmann entitled Essays on Ego Psychology (1964). So, Bowlby is probably psychoanalytically orientated.

From this example of a paragraph from Bowlby's work, it is possible to see how vocabulary and the citation of other writers can give a good indication of the philosophical orientation of an author.

3. How do other authors categorize these writers whose works are studied in this dissertation?

A major indication of the theoretical orientation of writers is to review how other prominent thinkers categorize them. Another clue is to consider the theoretical inclination of the journals which publish their work. For example, Eysenck and Wurberg in the Encyclopedia of Psychology (1972) credit Abraham Maslow with molding humanistic principles into humanistic psychology. Many other authors include Maslow's name under the category of humanism (e.g., Severin, 1965; Bugental, 1967; Child, 1973). With regard to periodical articles, Maslow helped to found the Journal of Humanistic Psychology and published several articles in this journal. In short, Maslow is seen by others as a humanist.

Also important is what authors state their theoretical orientations are. In other words, how do authors

categorize themselves? For example, in the preface to the second edition of Toward a Psychology of Being (1968), Maslow states the following about the first edition of this book: "Much has happened to the world of Psychology since this book was first published. Humanistic Psychology--that's what it's being called most frequently--is now quite solidly established as a viable third alternative to objectivistic, behavioristic (mechanomorphic) psychology and orthodox Freudianism" (Maslow, 1968).

So, not only do others view Maslow as a humanist, but that is how he describes himself. This method will be used to explain how authors were chosen to represent each group.

In summary, in this dissertation, authors will be categorized as psychoanalytic, behavioristic, or humanistic based on several points. First, they will be grouped according to the basic underlying principles or assumptions in their writings. Secondly, they will be evaluated by looking at their vocabulary. Thirdly, attention will be paid as to how others categorize them and how they classify themselves.

Definition of Terms

For the purpose of this dissertation, grieving is used as an alternative term for mourning. According to John Bowlby (1980), interchanging of the two terms is widely used by many psychoanalysts including Bowlby, himself. In fact,

mourning and grieving have been described in similar terms. Parkes (1972) describes grief as a reaction when a love tie is broken. "When a love tie is severed, a reaction, emotional and behavioral, is set in train, which we call grief" (Parkes, 1972, p. xi). Bowlby uses similar terms to describe mourning. Mourning "is used to denote a fairly wide array of psychological processes set in train by the loss of a loved person irrespective of their outcome" (Bowlby, 1980, p. 17).

In psychoanalytic terms, the definition of mourning sounds much like that of grieving.

> The process of mourning (Trauerarbeit) taken in its analytic sense means to us the individual's effort to accept a fact in the external world (the loss of the cathected object) and to effect corresponding changes in the inner world (withdrawal of libido from the lost object, identification with the lost object (A. Freud, 1960, p. 58).

Mourning is often also used to describe social customs related to the dead. That is, people may be said to be "in mourning". This term indicates that they have taken on the prescribed behavior of mourners.

Bereavement is the state or fact of having a loved one taken away through death (Jackson, 1962).

For purposes of this dissertation, the term depression will be used to describe an effect that is a normal part of the grieving process. The clinical pathological depression which is not a natural part of grief will be termed "depressive illness" (Jackson, 1957; Bowlby, 1980).

Summary

The purpose of this dissertation is to review, by means of historical research, how the psychoanalytic, the humanistic, and the behavioristic theories of counseling have been applied to the treatment of the bereaved spouse. The intent of this investigation is to determine the "state of the art" of each of these three theoretical frameworks in the treatment of a widow/widower who seeks treatment for a grief related psychological problem.

The historical analysis of each theory will include a developmental overview and review of existing literature, an analysis of the mourning process, the goals of the therapist, the process of treatment, techniques of the therapist, and criticism of the currently used therapeutic process. Both normal and pathological grief will be discussed (Parkes, 1972).

It is the tentative thesis of this study that the process of treatment of all three theoretical approaches to grief counseling may be similar despite their diverse origins and diverse views on the nature of man and the meaning of life.

CHAPTER II

PSYCHOANALYTIC THEORY

Historical Perspective and Review of the Literature

This section of the dissertation is a chronological presentation of the authors who are the major contributors to the literature which developed the "psychoanalytic theory" of the process of mourning in the grieving spouse. Although in this study primary emphasis is placed on the grieving process, the topic of fear of death has been mentioned because it contributes to an historical understanding of current psychoanalytic grief theory. Throughout early grief literature these two topics, mourning and fear of death, have been interwoven.

1. Sigmund Freud (1956-1939)

Any discussion of psychoanalysis begins with Sigmund Freud. Freud was a rare genius who was able to integrate the lessons of his teachers, Breuer and Charcot, together with clinical experience and self-analysis to establish a paradigm which would change the course of western thought. He was able to look inside himself and see all men. Freud also used the case studies of his patients to support his newly developing theories of personality.

Although the unconscious and infantile sexuality are the two major concepts which form the structure for psychoanalytic theory, death is also a major theme, appearing repeatedly in Freud's writings (Freud, 1909/1953, 1915/1957, 1916/1957, 1920/1955, 1926/1959, 1933/1964).

Several events in Freud's life caused him to be concerned with death. Freud's first intimate experience with death was probably that of his younger brother, Julius, who died when Freud was only nineteen months old and Julius was eight months old (Hamilton, 1976). In an 1897 letter to Fleiss, his only close friend at the time, Freud admitted that he had been jealous of his younger brother and had wished him dead (Freud, 1960). Later Freud experienced guilt because his wishes for his brother's death came true. From the experience of Julius' death, Freud proposed the theory of the "death instinct" (Hamilton, 1976). Rudimentary elements of the death instinct can be found in The Interpretation of Dreams (1900/1953). The fully formed "death instinct" theory emerged in Beyond the Pleasure Principle (1920/1955).

In 1894, Freud's father, Jacob, died. A few months later, Freud wrote to Fleiss that his father's death had upset him greatly and that he felt uprooted (Freud, 1960). Freud stated that the event of his father's death was the impetus for the beginning of his own psychoanalysis which occurred during the time he authored The Interpretation of

Dreams (1900/1953). It took Freud about a year to write his own self-analysis with regard to his father's death (Clark, 1980). The five years after Jacob's death are generally considered to be the most productive of Freud's years. According to Jones, "Eighteen ninety-seven was the acme of Freud's life" (Jones, 1953, p. 267).

In the Preface to the Second Edition of The Interpretation of Dreams Freud remarks that it was only after he finished this book that he realized how his father's death had influenced him. "It revealed itself to me as a piece of my self-analysis as my reaction to my father's death; that is, to the most important event, the most poignant loss, in a man's life" (Freud, 1908/1959, p. xxvi).

During these years Freud was also concerned about his own health, feeling certain that he would not live a long life. Freud was convinced that his heart was failing as his father's had. Experiencing the symptoms of the deceased is a common, albeit pathological, characteristic of a mourner (Freud, 1917/1957). Freud consulted with his physician, Fleiss, concerning his cardiac symptoms. Fleiss advised Freud that his symptoms were probably due to nicotine addiction from the constant smoking of cigars rather than from a serious heart condition. Freud abstained from nicotine for a time, but returned to his habit because it helped him to concentrate on his work.

Fleiss (1906) was interested in numerology. He calculated that Freud would live at least into his 60's (Jones, 1953). Freud took Fleiss' numerical approaches to life and death with a grain of salt, but Fleiss' reassurance of his long life seemed to relieve Freud's mind (Clark, 1980).

Another event which caused Freud to reflect on death was World War I. Freud was 58 when the war broke out, "his first response was . . . one of youthful enthusiasm, apparently a re-awakening of the military ardors of his boyhood" (Jones, 1955, p. 171). This enthusiasm lasted only a short time when it became apparent to everyone, including Freud, that the war would not end quickly. Freud had nightmares about the fate of his two sons who were fighting. In 1915, he published a paper, "Thoughts for the Times on War and Death" which addressed the horrors of war. It is generally agreed (Choron, 1962; Stotorow, 1973) that by about 1925 Freud had revolutionized the then current thinking on the fear of death.

Freud's own death was a slow process. He had cancer for sixteen years. At the age of 67 he developed cancer of the mouth from years of cigar smoking. He refused any medication for fear it would dull his mental capabilities and he was able to see patients until two months before his death. In 1939, Freud asked his life-long friend, Dr.

Schur, to end his life. Dr. Schur obliged by giving him a final dose of morphine (Schur, 1972; Golub, 1981).

With few exceptions, every volume of the Standard Edition (1953 to 1974) of Freud's work contains references to some topic regarding death and mourning. It is possible to divide Freud's writings on the subject of death and mourning into four groups (Hoffman, 1979): (1) the topographic model of the mind (Freud, 1913/1955, 1915/1957, 1917/1957) in which all statements about death focus on the unconscious. Here Freud attempted to describe the mourning process as it relates to the unconscious, the conscious, and the preconscious; (2) the concept of the death instinct (Freud 1920/1955, 1926/1959, 1933/1964); (3) the development of the structural model (Freud, 1923/1961, 1933/1964); and (4) the "existential" point of view restated and clarified in "On Transience" (Freud, 1916/1957). The following review of literature is organized according to these four categories.

Freud first attempts to devise a model of the mourning process in Totem and Taboo (1913/1955). In this book Freud examines primitive man to try to find the basis of neurosis. Freud thought that primitive man had an emotional immaturity similar to the emotional variance of the neurotic. Modern people had learned to gain more control over their emotions than their primitive counterparts, learning

how to avoid extreme swings of affect, that is, emotional ambivalence.

In Totem and Taboo (1913/1955), Freud shows how the process of mourning clearly illustrates the ambivalence of human emotions, the conflict of love and hostility. Mourning, "tends to be preoccupied with the dead man, to dwell upon his memory and to preserve it as long as possible" (Freud, 1913/1955, p. 57). Yet, primitive people fear the return of the deceased as a ghost. Some primitive tribes go so far as to place a taboo against allowing anyone to utter the name of the deceased because people's names are part of them. Saying the names of the deceased might bring them back.

So, although mourning attempts to preserve the memory of the deceased, the living fear the appearance of the dead person's spirit. It seems that what is longed for is the dead person as he or she existed in this world and not a return of a transformed, unpredictable, spirit self. This concept of ambivalence in mourning is very important because it helps to explain anger and guilt (Solomon, 1977).

In Totem and Taboo (1913/1955) Freud introduces other interesting topics including the unconscious basis of guilt in mourning, the restrictions placed on a surviving family by society, and how death of a loved one can increase fear of death in the survivors. These subjects are reviewed more fully in the pages to follow.

World War I brought death to worldwide attention and in 1915 Freud published his, "Thoughts for the Times on War and Death" which contained his personal reflections rather than documented research such as Totem and Taboo (1913/1955).

Since 1895, Freud had been concerned with melancholia, today known as clinical depression, and how it relates to mourning (Freud, 1960). In Mourning and Melancholia (1917/1957) he compares these two topics because of the obvious similarities of their presenting conditions. Freud speculates that the environmental conditions which started the two were the same. In this book, Freud describes the process of mourning as a conscious process. Melancholia, on the other hand, is at least partially an unconscious process. "Mourning involves grave departures from the normal attitude of life" (Freud, 1917/1957, p. 244). However, time will heal these wounds in most cases. When mourning turns into the abnormal process of melancholia, then probably a pathological personality disorder is present. In other words, mourning and melancholia were seen by Freud as being different processes.

Freud's concept of the death instinct was first published in Beyond the Pleasure Principle (1920/1955). After that time Freud gave free rein to his opposing ideas of Eros (the instinct for self-preservation) and the instinct for death or destruction. (Note: Freud did not use

the term, Thanatos to mean death instinct. It was first used by Federn.) According to Freud, "The picture which life presents to us is the result of the concurrent and mutually opposing action of Eros and the death instinct" (Freud, 1926/1959, p. 57).

Several authors influenced Freud in the development of his death instinct theory including Weismann (1893), a biologist, who wrote about how easily primitive organisms pass between life and death. He cites the example of a virus which can appear dead for many years, but when it is introduced to a media conducive to growth, it comes back to life. Weismann theorizes that living objects have instincts which cause them to struggle for life and other instincts which steer them toward death.

Freud (1933/1964) hypothesizes that the death instinct rises at the moment inorganic matter became organic. It is a movement to return to non-life. Life consists of the interaction between the erotic instincts which seek to combine more and more living substances into greater unities, and the death instinct which leads us back into an inert, non-living state. Death brings an end to the interaction between these two forces.

The death instinct immediately created a controversy which is still on-going (Wallace, 1976). A few psychoanalysts including Alexander, Eitingon, and Ferenczi accepted the death instinct concept when it was first introduced

(Jones, 1957), but the majority of analysts thought Freud was merely seeking attention with a basically unsound theoretical position (Clark, 1980). Today only a few psychoanalysts still use the term "death instinct" and their meaning is far removed from Freud's original meaning (Jones, 1957). For the purpose of this dissertation, the value of the death instinct theory is that therein lies Freud's definitions of life, death, and the relationship between the two.

In Inhibitions, Symptoms, and Anxiety (1926/1959), The Ego and the Id (1923/1961), and New Introductory Lectures (1933/1964), Freud develops his structural model of grieving. In these books he theorizes in terms of the ego, superego, and the id about how the process of mourning occurs. Interwoven with these ideas are Freudian speculations on the fear of death. Discussion of the fear of death is included in the following material on the structural model of mourning because Freud so closely associates these two concepts in his writing (Freud, 1913/1955).

The process of mourning is a difficult psychological task characterized by (1) reality testing (Freud, 1926/1959); (2) suppression of affect (Freud, 1926/1959); and (3) a degree of anger and blame which in excess is neurotic (Freud, 1933/1964). Reality testing is brought about by the bereaved encountering circumstances which remind them of the deep feelings which they had for the deceased. Freud

focuses on these encounters as the source of the pain in grieving. The survivors had during the life of the deceased directed libidinous energy toward their loved ones. Now that the loved one is dead, the libidinal energy is evoked by a memory of the deceased but the investment of libidinal energy (cathexis) cannot find resolution or satisfaction. "That this separation should be painful fits in with what we have just said in view of the high and unsatisfiable cathexis of longing which is concentrated on the object by the bereaved person during the reproduction of the situations in which he must undo the ties that bind him to it" (Freud, 1926/1959, p. 172).

In mourning there is often a suppression of affect and/or a continual flood of repressed sexual fantasies (Freud, 1926/1959). This suppression causes fatigue. Fatigue is a characteristic of depression which comes from repression of anger and other emotions.

Just as primitive people must always assign blame for the death of another (Freud, 1913/1953), some people blame themselves for the death of a loved one (Freud, 1933/1964). Excess anger and/or excess blame are a sign of neurosis (Freud, 1917/1957, 1933/1964).

The topic of a person's fear of his own death and/or the death of a loved one occurs repeatedly in Freud's writings. According to Jones (1957), Freud was more obsessed with thoughts of death than any other great man with the

exception of Sir Thomas Brown and Montaigne. This concern is reflected in his theories. Freud speculates in The Interpretation of Dreams (1900/1953) that because of adult fears of death, the mythology of an after-life was created. (As Freud approached death, he became more open to the possibility of life after death (Jones, 1957).) Children, on the other hand, have no fear of death since they equate death with absence (Freud, 1900/1953).

In Civilized Sexual Morality (1908/1959) Freud introduces his theory of a link between sexual repression and the fear of death. Sexual restriction leads to fear of death and anxiety about life. It causes a decreased interest in having children and leads to neurosis (Freud, 1908/1959). Oral eroticism (Freud, 1917/1957) or fear of castration (Freud, 1923/1961) can manifest themselves later as a fear of death. This fear of death may present itself in various ways including a phobia (Freud, 1917/1957), chronic anxiety attacks (Freud, 1917/1957), or obsessional neurosis (Freud, 1909/1955).

The structural mechanism of fear of death is, "that the ego relinquishes its narcissistic libidinal cathexis in a very large measure--that is, it just gives up itself, just as it gives up some external object in other cases in which it feels anxiety" (Freud, 1923/1961, p. 58). Fear of death is a function of tension between the ego and the superego. More specifically, the ego gives up itself because it feels

hate, not love from the superego. In other words, the ego gives up part of itself before its actual death.

Freud presents an existential point of view in "On Transience" (1916/1957). Freud speculates that the fact that beautiful things will not live forever does not decrease their worth, but rather increases their value. Specifically concerning mourning, in "On Transience" (1916/1957) Freud describes the libido as the capacity to love which could be freed and redirected through the process of mourning.

In summary, a review of the death and mourning literature written by Freud reveals a wide diversity of writing which, for the purpose of this dissertation, has been divided into four topics: a topographic model, the death instinct, a structural model, and an existential view. Despite Freud's prolific writing on the subject of death and mourning, authors dispute whether or not his ideas form a general theory of mourning (Nachman, 1981) or are merely a collection of related ideas (DeLeon-Jones, 1979). Even if Freud presents no general theory of mourning, the value of his work rests in the fact that he began the psychoanalytic study of mourning and presented a basis for further investigations and debate.

During Freud's time, other writers were studying grief reactions. Darwin (1872) and Shand (1920), although they were not psychologists, are cited in psychoanalytic

literature as having been important to psychoanalytic thought on mourning (Bowlby, 1961). Darwin studied the comparative facial expressions of man and animals. Illustrations in his book show how grief is a universal reaction to loss and how grieving animals show facial reactions and make sounds similar to a grieving human. This concept introduces the idea that grief has universal elements which may be observed. Shand uses the works of English and French authors to isolate the main characteristics of grief including fear and anger. Shand concludes that sorrow is very complex and that it affects people in various ways.

So, while Darwin (1872) points out a few commonalities shared by grieving people, Shand (1920) reminds us that each person is unique and although common traits emerge in bereaved people, each person's grief is somewhat different. These two concepts are central to an understanding of the grieving client.

In general, the psychoanalytic literature on mourning has been either (1) seeking explanations for behavior in the interplay between the conscious and the unconscious as in Freud (1913/1955), Klein (1940), and Bowlby (1963), or (2) seeking to study grief in a systematic way as in Lindemann (1944), Marris (1958), and Parkes (1971).

Post-Freudian psychoanalysts such as Anna Freud, Klein, and Erickson have written extensively on death and the mourning process. Erickson (1959) theorized that fear

of death is a sign of developmental failure. The acceptance of one's death is the successful completion of the final stage of life. The practicality of this point of view has been questioned because few people are able to see death as a positive experience (DeLeon-Jones, 1979).

Melanie Klein's (1940) work stresses how important infantile expressions of grief and mourning are to personality development. Anna Freud (1960) also studied children and recorded first hand observations of grief in infants and in young children.

2. John Bowlby (1907-)

John Bowlby, an English psychoanalyst, was born in 1907 in London. His father, Anthony Albert, was a surgeon and his mother's name was Maria. Bowlby married Ursula Longstaff on April 15, 1938 and they had four children, two boys and two girls.

He received his B.A. degree in 1928 and his M.A. degree in 1932 from Trinity College in Cambridge. In 1939 Bowlby received his M.D. from the University College Hospital Medical School with a specialty in psychiatry.

Bowlby has been a research psychiatrist and consultant psychiatrist at Tavistock Clinic from 1946 to the present. He has also served as a fellow of the Center for Advanced Study in the Behavioral Sciences at Stanford, California from 1957-58. From 1950 to the present, Dr.

Bowlby has been a consultant to the World Health Organization. He has won numerous awards including the G. Stanley Hall Medal from the American Psychological Association in 1974 (Kinsman, 1975).

His publications include numerous books and articles on such topics as the relationship between maternal care and mental health, the home life of juvenile thieves, and loss. Bowlby's most recent publications include three volumes of Attachment and Loss (1969, 1973, 1980).

Bowlby (1961) thinks psychoanalytic literature places too much emphasis on the trauma of loss from weaning and ignores the other types of losses including conjugal bereavement. Bowlby attempts to develop a more general theory of grieving. In Bowlby's model, experience and heredity determine how a person will react in a given situation. Attachments to loved ones are very important and permanent separation triggers behavior mechanisms which attempt to regain the lost object. Bowlby (1980) describes the grieving process in four stages: numbing, protest, despair, and detachment. This stage theory provides further research to support the idea that there is a common grieving process. Bowlby (1961, 1963) was the first to explain mourning in a normal population using psychoanalytic terms. For his clinical picture of normal grief, he uses his own work with a normal population of grieving children plus the

findings on normal adult grief of Lindemann (1944), Marris (1958), and later of Parkes (1971).

Freud (1913/1955) and Klein (1940) both stress the importance of ambivalence in mourning as an explanation for guilt and anger. Bowlby does not concern himself with this concept of ambivalence since he views anger and resentment as results of thwarted attempts to regain the deceased. In mourning there is a return to infantile emotive phases (Klein, 1940). When the mother leaves, a child will cry and attempt to regain her. In the same way, an adult in mourning cries to regain the lost loved one.

3. Erich Lindemann (1900-)

In the development of his model of normal grieving, Bowlby relied upon the research results of Lindemann (1944) and Marris (1958). Erich Lindemann was born in Witten, Germany, on May 2, 1900. He received his Ph.D. (1922) and M.D. (1926) degrees in Giessen, Germany. He was a resident in psychology and neurology in Heidelberg until he came to the United States in 1927. In the United States, Lindemann has served at some of the most prestigious schools and hospitals including Harvard Medical School and Stanford Medical Center (Cattell, 1973).

Lindemann accepted Freud's premises on mourning and melancholia and then went on to describe them (Glick, et al., 1974). He studied 101 survivors of the Coconut Grove fire in 1944 in New York. The historical significance of

his work is that he drew attention to the fact that grieving people share a common clinical picture including psychological and physical symptoms. Lindemann also recognized six traits of morbid grief. (These are discussed later in this dissertation.) He was the first to scientifically observe a large number of adults who had experienced the death of a loved one and the first to study grief on some basis other than single case studies as Freud had done.

Lindemann also introduced the concept of "anticipatory grief". Anticipatory grief occurs when one spouse expects that his or her loved one will die. The survivor goes through part of the grieving process prior to the death and this makes the grief work after the death somewhat easier. Lindemann (1944) illustrates how complete anticipatory grief can be when he relates the story of a soldier's wife during World War II. She was so sure that her husband would be killed and grieved so thoroughly for him, that when he returned from the war unharmed she was unable to take him back as her husband.

4. Peter Marris (1927-)

Marris (1958) studied 72 London widows two years after the death of their husbands. Despite the limited sample and the time lapse between the actual bereavement and the study, Marris offers one of the few early clinical studies of normal grief. Marris makes no reference to psychoanalytic theory, but his work is mentioned in this

section because Bowlby adopted Marris' model for normal grief.

Marris' study (1958) of 72 London widows reviews the twofold problems of widows, grief and poverty. He also isolates several symptoms of normal grief which confirmed the work of Lindemann. Problems with this study are the two-year span between the death of a spouse and the study itself and the limited sample, both geographically and age-wise.

5. Colin Parkes (1928-)

Colin Parkes is currently an important figure in grief research. Colin Murray Parkes was born on March 26, 1928 in London, England. His parents were Eric William and Gwyneth Anne Parkes. In 1958 he married a novelist, Patricia Margaret, and they had three children, all girls.

In 1951 Parkes received his M.B. and B.S. degrees from Westminster Medical School, London, followed by a D.P.M. in 1959 and an M.D. in 1962 from the Institute of Psychiatry in London. Parkes defines his religion as "humanism".

Parkes has served as a psychiatrist in numerous positions including Westminster Children's Hospital in London (1952), Maudsley Hospital in London, and the Tavistock Institute of Human Relations in London (1962-present). The Tavistock Institute is where John Bowlby is

also a psychiatrist. Parkes is also honorary consultant psychiatrist at St. Christopher's Hospice, Sydeham.

Parkes contributed to grief theory by performing clinical case study research to find patterns in the grieving client. Parkes' work is important because he elucidates the major phases of grief--expanding on the work of Bowlby, Lindemann, and Marris as they describe mourning (Solomon, 1977). Parkes (1974) sees normal grief as a functional mental disorder which, having a known cause with predictable symptoms, has a predictable outcome. Grief may be described as having four states: numbness, pining, mitigation or depression, and recovery (Parkes, 1974).

Parkes' studies include 21 psychiatric patients at Bethlem (1965), 21 widows not under psychiatric care in London (1971), and a book reviewing the literature (1972). With Glick and Weiss, he studies the first year of bereavement (1974). Parkes compares his findings at Bethlem (1965) with Marris' work with normal widows. Parkes found that most of the characteristics of Marris' normal population fit his abnormal group, except he found the pathological group had two additional features: (1) difficulty in accepting that the deceased person was actually dead, and (2) ideas of self-blame and guilt (Parkes, 1971; Solomon, 1977).

Several recent studies on bereavement show that grief reactions are the same all over the world (Glick, Weiss, & Parkes, 1974). These include: Hobson's (1964)

study of 40 widows in England; Harvey and Kistemaker's (1965) study of 24 widows in East Cleveland, Ohio; Clayton, Desmarais, and Winokur's (1968) study of 40 surviving relatives in St. Louis, Missouri; and Yamamoti's (1969) study of 55 Japanese widows.

In summary, the psychoanalytic study of grieving began with Freud whose familiarity with grief started with the death of his brother and later the death of his father. Although authors dispute whether or not Freud had a unified theory of grieving, they generally agree that Freud's views were the impetus which began a theoretical and clinical study of the grieving process. Current theoretical psychoanalysts such as Bowlby rely on the clinical studies of Lindemann, Marris, and Parkes as a basis of their hypotheses. Research has shown that grieving people share many common feelings and experiences; however, each person is unique and so every individual experiences grief in a unique way.

Psychoanalytic grief literature either seeks to <u>explain</u> the grief counseling process as it relates to the psychic structure or to systematically <u>describe</u> the grieving process. Those who seek to explain grief have reached no consensus as to the purpose of "grief work" (the psychological tasks of the mourner). That is, they disagree on how the mourning phase works. Those who have done the

clinical work to present a picture of loss, offer no explanation as to the process.

All authors would agree that there is a common grief process and that the type and intensity of reactions will vary. In short, the grief reaction will vary depending upon the type and intensity of the relationship that the survivor had with the deceased (Solomon, 1977).

Psychoanalytic Description of the Mourning Process

This section describing the mourning process is organized around the following five questions:

1. What are the characteristics of the normally grieving spouse?
2. Do these characteristics appear in stages? What are these stages?
3. How long does the grieving process last?
4. What is the difference between normal and abnormal grief?
5. Is grief an illness?

The answers to these questions will be taken from the works of Freud, Bowlby, Parkes, Lindemann, and Marris.

1. What are the characteristics of the normally grieving spouse?

Freud, Bowlby, Parkes, Marris and Lindemann agree that normal grief consists of the following eight characteristics:

(a) painful dejection and/or anxiety

(b) physical symptoms

(c) preoccupation with thoughts of the deceased

(d) lack of contact with the outside world

(e) taking over the identity and/or activities of the deceased

(f) hostility, anger, and/or guilt (oscillation of feelings toward the deceased which can lead to anger or guilt (Freud, 1913/1955))

(g) change in activity level

(h) reorganization

With reference to point (a) listed above, Freud (1917/1957) states that no one knows the exact process which makes mourning painful. He speculates that painful dejection results from the loss of a loved one in the normal environment. Bowlby (1961) thinks that the pain is due to the constant repetition of bitter disappointment at the spouse's continued absence. Parkes (1974), Marris (1958), and Lindemann (1944) describe despair as a feature of normal grief.

Physical symptoms were clearly defined by Lindemann. The "somatic distress" of grief which occurs in waves, lasts from twenty minutes to one hour. It is usually triggered by some reference to the deceased. In order to avoid these episodes of grieving, the bereaved may become socially withdrawn so as to reduce the probability of being reminded by others of the loss. Symptoms of this distress are

exhaustion (Freud, 1917/1957), crying, and tension (Lindemann, 1944). Some patients feel such strong grief reactions that they fear they are becoming psychotic. Other physical symptoms include weight loss, inability to concentrate, and insomnia (Lindemann, 1944; Marris, 1948; Bowlby, 1960; Glick et al., 1974). Statistical relationships exist between bereavement and an increased death rate (Young, Benjamin & Wallis, 1963; Rees & Lutkins, 1967; Parkes, 1969).

Evidence exists that some bereaved people experience the same symptoms as the dead person (Freud, 1917/1957; Parkes, 1972; Glick et al., 1974). For example, if a man died suddenly of a heart attack, his wife might experience heart pains and fear that she too was ill. Parkes finds this to be a part of normal grief. Freud holds the contrary opinion that experiencing these symptoms is not normal. Mourning often includes reproach for one's death and punishment of oneself by experiencing the same symptoms as the lost person. That is, imitation of symptoms is regarded by Freud as a form of self-punishment which appears in abnormal grief.

Another characteristic of spouses who are grieving normally is preoccupation with thoughts of the lost person which derives from the urge to search for that person (Marris, 1958; Bowlby, 1961; Parkes, 1972). "There is painful repetitious recollection of the loss experience,

which is the equivalent of worry work and which must occur if the loss is not fully accepted as irrevocable" (Parkes, 1972, p. 77). Mourning, "tends to be preoccupied with the dead man, to dwell upon his memory and to preserve it as long as possible" (Freud, 1913/1955, p. 57). The bereaved spouse attempts to understand why the loss happened, to gain an intellectual understanding.

As the bereaved people go about their normal activities, they find that much of this activity involved the dead person. This activity now has no meaning. For example, cooking dinner may now seem pointless, or social interaction with friends may now be gone (Lindemann, 1944; Bowlby, 1960). Although the deceased spouses are gone, their presence is still felt (Marris, 1958).

Freud (1917/1957) discusses how reviewing thoughts of the deceased are an important part of mourning. Each memory must be remembered, examined, and released with the new knowledge that the deceased is part of the past, but not the present.

(d) Lack of contact with the outside world. Bereaved people show a lack of interest in the outside world which does not recall the deceased. There is a lack of interest in any activity which does not perpetuate the memory of the deceased. Also, there is little interest in finding a new love because this would replace the deceased (Freud, 1917/1957). Withdrawal and regression are common

(Bowlby, 1960). It is too painful for the bereaved to face situations which will bring to reality the idea that their loved one is really dead (Glick, et al., 1974). By avoiding social contact, they can live in a delusion that their spouses are still alive. Marris (1958) describes this withdrawal from the outside world as a loss of contact with reality which results from an inability to comprehend the loss.

Sometimes the survivors think that they see their spouses again (Lindemann, 1944; Glick, et al., 1974). Perhaps the deceased people appear in the hall or at the dinner table. This is a common phenomenon in the recently bereaved.

(e) Taking on the identity of the deceased. Mourners may gain a new identity during bereavement by taking over the roles previously performed by the deceased. It is as if the lost object is never truly given up, but becomes a part of oneself (Freud, 1913/1955; Parkes, 1972). The identification serves the purpose of providing a feeling of closeness with the deceased and is a way of taking over the roles that must be assumed (Marris, 1958; Parkes, 1972). For example, Parkes (1974) cites the case of the widow who tended her husband's garden with great care, although she had no interest in this hobby before his death. Lindemann (1944) also cites examples of people who take on the behavior, traits, or illness of the deceased.

(f) Anger, hostility, or oscillation of feeling toward the deceased. The process of mourning clearly illustrates the ambivalence of human emotions, the conflict of love and hostility (Freud, 1900/1953, 1913/1955). For example, mourners try to preserve the memory of the deceased for as long as possible, while fearing the return of the departed in the form of a ghost. So, although mourning attempts to preserve the memory of the deceased, the living fear the appearance of the dead man's spirit.

This ambivalence can lead to anger and guilt, which Freud (1917/1957) sees as components of abnormal grief. Others disagree, saying that anger is a component of normal grief (Bowlby, 1960; Parkes, 1972) which occurs especially during times of intense pining (Parkes, 1971). Hostility is often directed at helpers (Lindemann, 1944; Marris, 1958) or it may later turn inward and become depression (Parkes, 1972).

Bowlby's (1960) view of anger and resentment is not based on Freud's idea of ambivalence (Solomon, 1977). Yet he does discuss oscillation of feelings (Eliot, 1955; Bowlby, 1960).

Whatever the cause, some degree of anger is currently considered normal in the grieving process.

(g) Changes in the activity level. Lack of organized activity, aimless behavior, is common in bereaved people (Freud, 1917/1957; Lindemann, 1944; Marris, 1958).

This "hyperactivity" in grief is seen by Lindemann (1944) as aimless wanderings, but others disagree by saying that this activity is purposeful searching for the lost spouse (Bowlby, 1961; Parkes, 1972). Bowlby (1961) sees calling and searching as adaptive instincts in children which occur in the bereaved adult.

(h) Reorganization. Finally, reorganization occurs. The survivors are able to shift their attention, or libidinal energy (Freud, 1917/1957) from the departed to a new object or interest (Bowlby, 1960; Parkes, 1972). These new interests may include dating (Lindemann, 1944), remarriage (Marris, 1958), or adjusting to life as a single person.

Some additional problems may be faced by a widow/widower. These are:

1. resistance to change
2. stigma
3. deprivation (Parkes, 1972)

Resistance to change, that is to giving up possessions, friends, shared activities, status, and expectations, is the main problem caused by grief (Parkes, 1972). This problem is especially true in the case of widows. Often a wife's social activities and status hinge on her husband's career. Frequently their activities involved other couples. When her husband is dead, a widow may find herself socially isolated. Even if couples invite her to attend functions, she may feel out of place or find them painful.

Similarly, a widower may have relied on his wife for the arrangement of social events. Perhaps she instituted meetings with friends and family. Her death would cause a great gap in the social contacts of the widower (Bowlby, 1980).

Stigma of the survivor is discussed by Freud in Totem and Taboo (1913/1955) where he collects numerous examples of primitive tribes such as the Shuswap of British Columbia, and the Agutainos of the Phillipines who ostracized their widows and widowers. They were made to carry a stick to beat on trees to warn others of their approach because looking at a widow or widower could mean death until the purification rite had been completed. Modern survivors still feel social isolation in the sense that people with whom they previously felt comfortable now appear strained in their presence (Freud, 1917/1957; Marris, 1958; Parkes, 1972).

Deprivation for the mourner may be of many types including loss of income and insurance (Marris, 1958), lack of love, lack of companionship, and lack of sexual relations. Loneliness is the reaction to deprivation (Parkes, 1972). Often lack of income presents monumental problems, especially for a widow who had previously been a housewife and mother of young children (Marris, 1958).

2. Do these characteristics appear in stages? What are these stages?

Freud, Marris, and Lindemann describe the process of mourning, but do not attempt to define stages of grieving.

In an early paper, Bowlby (1961) suggests that the courses of mourning could be divided into three stages, but this numbering omitted an important first phase which is usually shortlived. In 1980, Bowlby renumbers his phases to make room for the formerly omitted first stage, numbing. The four phases are as follows:

1. Phase of numbing that usually lasts from a few hours to a week and may be interrupted by outbursts of intense distress and anger.
2. Yearning and searching which lasts for months and sometimes years.
3. Disorganization and despair.
4. Phase of a greater or lesser degree of reorganization.

The first phase, numbing, occurs immediately after the death. The surviving spouse is stunned and unable to accept the news. Emotional variance occurs in the form of attacks of anger, panic attacks, or periods of extreme tension. This stage lasts for a few hours or a few weeks.

In the second phase, yearning and searching, the mourners attempt, often unconsciously, to recover the lost person. This stage may last for months or sometimes years. Bewildered, they act as if the deceased spouse is still

there. The main features of this stage are weeping and anger. Anger may be directed at helpers if they attempt to convince the survivors that the person is actually dead. The survivors do not want comfort. They want their loved ones back. Other features of this stage are pining, some degree of grief pangs, and some degree of self-reproach although guilt should never be as prominent as anger.

Stage 3, despair and disorganization, begins when attempts to maintain patterns of behavior and to retain the lost one are thwarted. That is, reality begins to set in and a little at a time, the finality of the loss becomes clear. Depression (Bowlby, 1980), behavior that is not organized and self-sustaining, is often a prominent feature of this stage. In this stage,

> it is necessary to discard old patterns of thinking, feeling, and acting before new ones can be fashioned, it is almost inevitable that a bereaved person should at times despair that anything can be salvaged and, as a result, fall into depression and apathy (Bowlby, 1980, p. 94).

Loneliness is common, especially at night.

In stage four, reorganization, the persistence of behavior oriented toward the lost object becomes modified. Gradually, new interests are found to replace the deceased. This stage correlated with Freud's explanation in Mourning and Melancholia (1917/1957) of how the libidinal attachment is removed from the deceased and directed elsewhere. Behavior might include resuming a social life, learning new

skills, becoming the family wage earner, becoming a housekeeper or becoming responsible for child care.

Parkes (1972) describes a four stage model of grieving which influenced Bowlby to add the numbing stage to his grief scenario. Although Parkes' four stages are similar to Bowlby's, they are discussed herein because Parkes emphasizes different features seen in these stages. Parkes describes the following stages: numbing, yearning and searching, mitigation, and recovery. These stages of grieving occur as four separate clinical pictures. They generally occur in this order, but the mourner may move back and forth between phases.

Stage one, numbness, is a state of alarm characterized by shock and disbelief (Glick, et al., 1974). Psychosomatic distress is common including rapid heartbeat, dryness of mouth, and a general increase in tension. Eighteen of 22 women in Parkes' study felt restless during the first month, a restlessness which might approach panic. Seventeen of 22 lost weight (Parkes, 1972). There was also disorganization which made the completion of normal tasks impossible (Glick, et al., 1974). Helpers were often needed to complete routine work such as helping with the children or preparing meals.

Stage two, yearning and searching, is characterized by pining, "a persistent and obtrusive wish for the person

who is gone, a preoccupation with thought that can only give pain" (Parkes, 1972, p. 40). There is an urge to search for the lost one. Symptoms include tension, restlessness, preoccupation with thoughts of the deceased, development of a perceptual set for that person, and loss of interest in personal appearance and normal activities.

In pining, there is a direction of attention toward places where the deceased used to be and calling for the lost spouse. Lindemann (1944) describes this as continual searching; however, he sees it as aimless behavior while Parkes views this searching as a purposeful attempt to find the loved one. For example, a widow might return to the church where they were married, or to favorite places where she and her spouse had enjoyed pleasant memories.

In the third stage, mitigation, the survivor tries to lessen the pain. The commonest method is, "the maintenance of a feeling or impression that the bereaved person is nearby although he can't be seen or heard" (Parkes, 1972, p. 57). There is an avoidance of painful thoughts and an avoidance of people and situations which will offer a remembrance that the person is dead. This included a suppression of sexual desire (Glick et al., 1974). Pain is also avoided by a lot of activity. Depression often occurs at this stage.

In the fourth stage, recovery, physical, emotional and intellectual activity begin to return. The preoccupa-

tion with the deceased decreases and new interests supplant the old.

It seems clear, that with semantical differences, the grief models of Bowlby and Parkes are similar. These models reflect the work of others such as Freud, Marris, and Lindemann who did not see the necessity of delineating stages of this process.

Some theorists dispute the view that the grieving process occurs in stages. For example, Shneidman (1976), who is not necessarily psychoanalytically oriented, believes that the grieving person does experience isolation, envy, anger, depressions, bargaining, and acceptance at various times, but does not experience them in stages. Shneidman describes instead a, "complicated cluster of intellectual and affective stages, some fleeting, lasting for a moment or a day or a week, set, not unexpectedly, against the backdrop of that person's total personality, his 'philosophy of life'. . ." (Shneidman, 1976, p. 446).

3. How long does the grieving process last?

Estimates on the duration of grief vary. In "A Case of Obsessional Neurosis" (1909/1955) Freud studied the case history of a man's illness which worsened after the death of his father. This illness was a pathological expression of grief. Freud concluded that normal grief lasts from one to two years, but pathological grief goes on indefinitely.

Lindemann (1944) estimated the time of grieving to be from 4 to 8 weeks. Of course, his research project lasted only a few weeks. According to the findings of Parkes (1972) and Bowlby (1980), it seems likely that a follow-up study would have revealed a longer period of mourning for these subjects.

Marris (1958) found that grieving time varies greatly from individual to individual. It might persist for only weeks, or last years. He found some of the widows in his study to be grieving after two years.

Parkes (1974) found that after two months the widows felt that they were going to be all right. At this time 61% said that they were beginning to feel like themselves again. Further recovery was slower and seemed to not be achieved until the last months of the first year. At the end of the first year most believed that they had done well. After one to three years they no longer mourn actively, but the loss remains a part of them and from time to time they have pangs of grief. Although these lessen in intensity and frequency (Glick et al., 1974). Parkes concluded that the grieving process varies widely from person to person.

In summary, it can be said that grieving varies greatly according to the individual, but the one year point seems to be one of marked lessening of pain. Usually after one year some reorganization occurs such as moving to a new house, redecorating the current home, establishing new

social activities, or engaging in new professional or educational experiences. Although the loss experience never leaves the survivor, active grieving past 1 or 2 years is not considered normal.

4. What is the difference between normal and abnormal grief?

Freud (1916/1957) described normal grieving (mourning) as one process and abnormal grieving (melancholia) as a distinctly different clinical picture although their causes were probably similar. According to Freud, mourning is a normal response to the loss of a loved one. Although mourning involves grave departures from the normal attitude of life, it will be healed by time. Mourning occurs on a conscious level.

On the other hand, melancholia, abnormal grieving, occurs on an unconscious level. It is characterized by ambivalence toward the deceased and unconscious conflict. Abnormal grief develops as follows:

1. An object is lost.
2. There is a normal displacement of libido from this object onto a new one.
3. The free libido is withdrawn into the ego.
4. The libido establishes, "an identification of the ego with the abandoned object" (Freud, 1916/1957, p. 249).

5. The ego judges itself as if it were the lost object.

So, the object-loss becomes an ego-loss and there is a conflict between the former ego and the new ego which had been transformed by identification with the deceased. In other words, the spouses could transform the loss of their mates into loss of self. Conflict exists when they transform their own identity by identifying too closely with the deceased. Freud theorized that narcissistic personality types are more prone to melancholia than other types.

Abnormal grief is characterized by duration past one or two years, excessive anger and guilt. Guilt and anger result from ambivalence between love and hate of the deceased. Wishing for the death of another, suppressed hostility, produces guilt (Freud, 1916/1957).

Lindemann (1944) described the following features of abnormal grief:

1. delay in reaction. Grieving should begin within the first few weeks. After 10 weeks is considered an abnormally long time for the onset of grief following the death.
2. distorted reactions including
3. overactivity without a sense of loss
4. medical disease
5. changes in relations with friends and family
6. furious hostility

7. schizophrenia
8. lack of initiation of social activities
9. self-punishment such as giving away money and other guilt related activities
10. agitated depression (adapted from Lindemann, 1944, pp. 144-146).

Bowlby (1961) agrees with Lindemann that abnormal grieving is exaggeration of the normal process. Bowlby sees these abnormal clients as being locked into the second stage of mourning of yearning and attempting to recover the lost one. Seeking a reunion is the main feature of pathological grief according to Bowlby.

Parkes (1965, 1971, 1972) finds normal grieving and abnormal grieving to be similar with the exception of two additional features found in abnormal grieving:

1. long-term difficulty in accepting that the deceased is actually dead
2. ideas of self-blame and guilt

Also, morbid grief lasts longer and is more intense than normal grief. Two types of abnormal reactions are prolonged grief and postponed grief (Glick et al., 1974).

Parkes (1972) describes three warning clues that abnormal grieving is occurring. They are grief postponed (longer than 2 weeks), excessive guilt, and taking on the physical symptoms of the deceased without other types of identification. Refusal to grieve in a timely manner

(within two weeks according to Parkes or within 10 weeks according to Lindemann) indicates denial which can lead to a prolonged mourning period, and possibly can lead to pathology.

In 35 abnormally grieving clients 21 suffered from depression, 6 were alcoholics, 5 presented hypochondriacal symptoms similar to the deceased, and 4 suffered from phobic symptoms. Other psychosomatic symptoms included panic attacks and hair loss (Parkes, 1972).

In summary, although Freud saw normal and abnormal grief as two separate processes (Solomon, 1977), current writers such as Parkes (Glick, et al., 1974) see these two types of grief to be on opposite ends of a continuum with no distinct line separating the two. Yet, agreement exists that several features indicate that abnormal grief is more intense and more prolonged than normal grief. Guilt and excessive anger, which can result in self-punishing activities including depression and physical illness, are common to abnormal grief.

5. Is grief an illness?

Freud (1916/1957) states that mourning is a normal process during which the pain of loss is healed by time. Freud describes in "On Transience" (1916/1957) how mourning is a natural process which runs its course and comes to a spontaneous end. Grieving is a part of everyday life as nature shows us through its seasonal death. On the other

hand, others treat grief as an illness (Lindemann, 1944; Bowlby, 1961; Parkes, 1972). Bowlby (1961) agrees that although the process of grieving is predictable, it is a state of "biological equilibrium" which must be treated the same as an injury or any other illness.

Society illustrates that the grieving process is an illness by treating the bereaved the way a sick person is treated (Parkes, 1972). Food is prepared for the mourners and their everyday tasks are assumed by helpers.

Common agreement exists that a person in mourning experiences pain and severe departures from everyday life. Whether or not grief should be treated as an illness is a moot point.

Goals of the Grief Counselor

Psychoanalytic grief counselors see their goals as centering on two issues:

1. To help the bereaved separate themselves from the deceased by breaking the bonds between them (Lindemann, 1944).
2. To help the bereaved adjust to new environments (Lindemann, 1944) and to form new relationships (Freud, 1917/1957).

The first goal, to separate from the deceased, is first discussed by Freud in "Mourning and Melancholia" (1917/1957). He hypothesized that the task of the bereaved was to transfer libidinal energy from the deceased to a new

interest or loved one. In order to allow this release to occur, the therapist attempts to free the clients emotionally (Parkes, 1972). Often blocks or repressed ambivalence prevent the grieving process from progressing normally. The counselor encourages the client to express this anger and guilt (Lindemann, 1944; Bowlby, 1960). Additionally, the counselor must encourage the client to accept the discomfort of grief (Lindemann, 1944).

The second goal, readjustment to a new life and to new relationships, occurs gradually. As the libidinal energy is slowly released from the deceased, it seeks new objects for attachment (Bowlby, 1969). Grieving is not completed until this readjustment takes place (Lindemann, 1944).

In summary, "Grief is a process of realization, of 'making real' the fact of the loss" (Parkes, 1972, p. 156). The next section will discuss how the counselor accomplishes these goals.

Process of Counseling

Before the actual process undertaken by the psychoanalytic grief counselor is discussed, one must first ask who needs counseling. Does every person whose spouse dies need to visit a counselor? The consensus among psychoanalytic counselors is that not everyone needs grief counseling.

Freud (1916/1957) emphatically states that mourning is a normal process and that psychiatric intervention is unnecessary and probably harmful to the client. Only mourning which becomes melancholia, abnormal grief, needs professional attention. Lindemann (1944) also thinks that counseling should be reserved for problem grieving and that "a few sessions" with a psychiatrist should be enough to release normal grieving.

Parkes (Glick, et al., 1974) also views abnormal grief as requiring psychiatric care, and often hospitalization. Yet, he introduced the idea of training helpers, paraprofessionals, and community mental health workers to offer support to normally grieving clients. He states (1974) that the care of the bereaved is a community responsibility. Bowlby (1980) agrees with Parkes' view and stresses that counseling has proven to be effective in preventing abnormal grieving. Bowlby (1980) cites the work of Raphael (1977) who set out to test the success of therapeutic intervention when given to widows whose mourning was predicted to go badly. (For reference to what these predictors are see Klein, 1940; Gorer, 1965; Maddison and Walker, 1967; Raphael, 1977; Vachon, 1982.) A total of 194 widows were divided into three groups as follows: group A (N=122) was predicted to have a good outcome and receive no counseling, group B_1 (N=27) was predicted to have a poor outcome and they volunteered for counseling, group B_2 (N=29)

was also predicted to have a poor outcome but they received no counseling.

The results showed no significant difference in outcome between group A and group B_1, thus showing that the counseling intervention had made the group which started out poorly (B_1) equal to the group which started out with a good prognosis. Secondly, the outcomes of group B_1 are significantly better (P .02) than those of group B_2 who received no counseling. The difference between group A and group B_2 is also statistically significant (P .001).

"The conclusion that counselling is in some degree effective is strongly supported by internal evidence derived from a detailed study of the 27 widows in the counselled group, 21 of whom did well and six of whom did badly" (Bowlby, 1980, p. 198). It was also found that those who made good use of the counseling sessions did better in the final outcome.

This study has been included to show that counseling has been beneficial as a means of preventing abnormal grief in those widows who were predicted to have severe problems with their loss. Some are seeing the benefit which counselors and helping paraprofessions can provide for the bereaved person in preventing long-term mental illness which might otherwise require years of treatment and hospitalization.

What actually happens when the bereaved comes to the grief counselor? The first step is to encourage the bereaved to talk freely about the experience leading up to the death and what happened afterward (Parkes, 1972; Bowlby, 1980). Their lives together should be discussed including how they met, married, and lived. Counseling in the home setting is useful because the deceased seems very present there. If the bereaved talks about memories, although conversation may be painful, the result will be that the memories can later be experienced without pain (Corazzini, 1980). Freud (1916/1957) calls this process hypercathexis which detaches the libido and frees the ego.

Also, anger and guilt must be expressed whenever yearning and sadness seem to be inhibited or misdirected. These open discussions will prevent the blocking and later suppression of affect which causes abnormal grieving (Parkes, 1972; Glick, et al., 1974). Raphael (1977) found that talking about the deceased and free expression of emotions are generally not encouraged by society. So, the counselor must first be a listener for painful material.

The second step in counseling is to encourage the processing of valuable information that had previously been excluded (Bowlby, 1980). This is information processing.

> For it is only when the detailed circumstances of the loss and the intimate particulars of the previous relationship, and of past relationships, are dwelt on in consciousness that the related emotions are not only

> aroused and experienced, but become directed toward the persons and connected with the situations that originally aroused them (Bowlby, 1980, p. 200).

For a more specific analysis of the grief counseling process, the following chart (suggested by Corazzini, 1980), lists some counseling skills that are needed and the response of the bereaved to these skills:

Counseling Process

Counselor	Bereaved
remain open to the loss	perceive the openness
be empathetic	express one's feelings
encourage remembering	reminisce
insist on the reality of the loss	acknowledge the loss
encourage expression of anger and guilty when they inhibit yearning and sadness	release of anger and guilt
encouraging the finding of the origin of certain feelings (Paul & Grosser, 1965; Lieberman, 1978).	self-discovery

In summary, the process of counseling includes encouraging the bereaved to tell of the experience of the loss and to express the emotions that they are experiencing. Special attention needs to be paid so that anger and guilt do not block the normal grieving process. Finally, the experiences and emotions of the loss need to be considered in light of previous loss and feelings. In other words, the loss needs to be put in perspective.

Techniques

The following techniques have been recommended as being helpful in the psychoanalytic counseling of the bereaved:

1. transference
2. drugs
3. safe surroundings
4. linking objects
5. mental health programs and groups

Transference is a phenomenon first observed by Freud in his treatment of Anna O. He noticed that she was projecting her feelings for her deceased father onto the therapist. Freud found this transference of feelings to be beneficial for the client. In treating melancholia (1916/1957), Freud suggested that transference be used as a tool by which the clients could work through their ambivalence toward the deceased, openly expressing the anger and guilt which were blocking the road to recovery.

Lindemann (1944) also mentioned the use of transference in grief counseling when he advised the psychiatrist to encourage that hostility felt for the deceased be directed against him, the therapist. This provides a needed emotional release (Fleming & Altshul, 1963; McCann, 1974; DeLeon-Jones, 1979).

Transference is "A general phenomenon of the perception or interpretation of current situations in the light

of past experiences or similar past experiences" (Eysenek, et al., p. 347). Feelings are often directed toward the therapist without any cause. These feelings are frequently held over from past relationships, only to emerge in the counseling situation. "In psychoanalytical terminology . . ., the term indicates primarily the phenomenon of emotional adjustment of the patient to the psychotherapist in analogy to the emotional adjustment of the patient to his early and earliest (interfamilial) reference persons" (Eysenek, et al., p. 347).

Transference can be positive such as when feelings of love or respect are exhibited or it can be negative when anger, hate, resentment and similar emotions are presented. However transference is manifested, it is a useful tool for the therapist who is able to observe emotions heretofore hidden. The release of emotions in grief counseling is, of course, necessary to free the libidinal energy formerly invested in the deceased loved one.

The use of drugs in treating the grieving client is a disputed issue. Lindemann (1944) was in favor of the temporary use of tranquilizers after bereavement finding that after a few weeks most of his clients voluntarily stopped taking them. Parkes (1972) suggests that sedation just postpones grief and that this postponement is unhealthy. Alcohol addiction during the grieving period is a real danger (Marris, 1958; Parkes, 1972; Bowlby, 1980). As

previously mentioned, grief which does not begin promptly after the loss is an indication of abnormal bereavement.

In short, concerning the use of drugs, "the fact remains that until the effect of tranquilizing drugs and anti-depressives have been properly assessed, they should be used with caution following bereavement" (Parkes, 1972, p. 173).

Safe places, safe people, and safe situations should be encouraged for some time after bereavement (Glick, et al., 1974). After the death of a loved one, the spouse often feels an unsettling which causes generalized fear and anxiety. If the spouse can die, survivors may fear what else unfortunate could happen to them. To minimize their fears, the bereaved should be encouraged to stay in familiar surroundings. A move to a new home right away should be discouraged.

Similarly, safe people should attend the bereaved. This includes family members and close friends, clergy and professional people such as counselors and lawyers. There are people who have reason to share the loss with the survivor and who understand the pain of the bereaved.

A safe situation is one which keeps the bereaved busy without taxing their resources. These situations should allow the grieving freedom to work or not work so that they avoid feeling trapped. To return to a normal life too fast postpones grieving.

Linking objects (Glick, et al., 1974; Bowlby, 1980) are things which remind the grieving clients of their lost one. Examples are old photographs, old letters, or personal belongings of the deceased. By looking at the linking object, the memories of the deceased are brought back, and this releases a beneficial flood of emotion. As previously mentioned, emotional release is an indispensible part of mourning.

Finally, Parkes (1972) and Bowlby (1980) suggest that community health agencies must provide help for the bereaved. This can include self-help groups where the grieving clients share their memories and their problems. These groups should not follow a time-table for entering different stages of grief. Instead, they should focus on emotional support. A rough groundwork can be provided to the bereaved so that they know what to expect. Also, they may be given information about a wide range of coping techniques which have been used by others.

In summary, some specific techniques which have been used by psychoanalytic grief counselors are: transference, drugs, safe surroundings, linking objects, and mental health programs. All of these techniques are aimed at providing support for the bereaved so that they may be free to pursue the work of grieving.

Criticism

Freud's ideas concerning mourning and melancholia are extremely complicated and subject to heated debate. For example, the fact that Freud stresses guilt in abnormal grief has been interpreted as Freud's personal neurosis (Wallace, 1976). Some argue that Freud's concept of "survivor's guilt" is the result of his own guilt over the death of his brother and the death of Ernest Von Fliesch1, a close friend. Von Fliesch1 died of addiction to cocaine which had been prescribed by Freud (Jones, 1953). Freud is also criticized (Bowlby, 1961) because he draws his conclusions from an abnormal population.

Another disputed psychoanalytic concept centers on libidinal energy, mental energy, which must be diverted from the deceased spouse to a new interest. Psychoanalytic critics argue that Freud and his followers have not described libidinal energy satisfactorily. They propose that the libidinal concept is a vague idea upon which the entire psychoanalytic grief theory has been built. In other words, the foundation of the entire theory is weak. Because "mental energy" is such an unclear concept, counselors have turned to other theories of the grieving process instead of psychoanalysis (Glick, et al., 1974). This mental energy is not measurable and is such an etheral concept that psychoanalytic theory ignores attempts at an explanation of how the grieving process actually works. Further, since the

grieving process is not understood, the counseling process is also unclear.

Lindemann's work (1944) is criticized as being oversimplified (Glick, et al., 1974). His study was too short and offered no follow-up (Solomon, 1977).

Bowlby's work is criticized by Parkes (1972) because he contradicts psychoanalytic theory by saying that grief has a biological function which promotes reunion. According to Parkes, psychoanalytic theory suggests that grief promotes detachment. It seems that grief does promote both reunion and detachment. When reunion fails, detachment occurs.

An observation, although not a negative criticism of psychoanalytic grief counseling literature, is that the studies cited to support psychoanalytic concepts are not necessarily written by psychoanalytically oriented authors. For example, Bowlby cites the work of Raphael (1977) without any reference to his theoretical orientation. Parkes (1974) also lists studies without reference to their theoretical basis. The psychoanalysts seem willing to look at research first on the basis of scientific merit regardless of the theoretical viewpoint of the author.

The psychoanalytic approach to grief counseling has been criticized by behaviorists as being too nondirective and too time consuming (Ramsay, 1976, 1977). Ramsay suggests that talking and waiting for spontaneous remission are

ineffective ways of dealing with grief which require lengthy and unnecessary hospital expense and time.

A review of this chapter reveals that the bulk of the psychoanalytic literature on bereavement is aimed at describing emotional aspects of the grieving process and at isolating the common feature of bereavement. It is generally agreed that the process of grieving is separation of self from a lost object and preparing to reattach the self to a new love object. Rudimentary attempts at developing a theory of the dynamics of the grieving process and the dynamics of the grief counseling process have begun. The success of grief counseling has been verified. Now researchers are working to isolate personality characteristics which may predispose a person to grieve abnormally. With this information, preventive intervention may be possible to help the bereaved to avoid abnormal grief.

CHAPTER III

HUMANISTIC THEORY

Historical Perspective and Review of the Literature

Humanism is a philosophical orientation which affirms the importance of human beings. The term humanism includes a large scope of diversified thinking, but several principles are held in common by all humanists whether they be religious or non-religious. People are seen as dignified, rational beings, possessing within themselves an ethical sense of right and wrong. Each person has the capacity to follow his or her own conscience and need not rely on outside sources to dictate individual behavior (Eysenek & Wurberg, 1972).

Humanism began in the 5th century B.C., when Greek philosophers turned their study from physical nature toward the study of human beings. Ancient Greeks and Romans such as Aristotle, Plato, Socrates, Protagoras, and Cicero developed the basic concepts of humanism.

During the Middle Ages, humanism was repressed as were other intellectual studies. Humanism emerged again about 1500 A.D. at the beginning of the Renaissance when the writings of the Greeks and Romans were rediscovered. In England, popular humanists were John Colet and Sir Thomas

More who was put to death for disputing the authority of the pope with Henry VIII. In the Netherlands, Erasmus (1466-1536), a Roman Catholic priest, attempted to reconcile humanistic views with the teachings of the Church. Erasmus called his religion the "philosophy of Christ" which was based on a love of all human beings (Bolgar, 1954).

In the West, humanism changed the course of history through people such as Thomas Jefferson, George Washington, Abraham Lincoln, and Eleanore Roosevelt. These humanists all fought for the human rights and the innate dignity of each person. Irving Babbitt, P. E. More, and Jacques Maritian are 20th century humanists whose writings reaffirm people's innate goodness which steers them toward a higher order. Ultimate reality is said to exist within each person and to be expressed in service to others.

Abraham Maslow (1909-1970) is credited with molding humanistic principles into a humanistic psychology (Eysenek & Wurberg, 1972). Although Maslow was trained by E. L. Thorndike and other behaviorists, he broke away from their influence by developing the "third force" in psychology. His psychology is based on a positive approach to the study of people and a positive view of their capabilities (Maslow, 1968, 1970, 1972).

Humanistic psychologists examine "Man in his wholeness" (Buhler, 1967, p. 83). A major part of the study of humankind deals with questions about the meaning of life

and death. What meaning does life itself have? Is there order to the universe (Frankl, 1959) or are people pawns of fate battered by life's storms (Kushner, 1983)? Why must people die? Does the fact that people die negate the fact that they lived? And, most importantly, why do individuals choose to live at all (May, 1969)? "There is but one truly serious problem, and that is ... whether life is or is not worth living" (Camus, 1955, p. 3).

Humanists speculate that these questions concerning humankind's existence are at the root of much fear, especially fear concerning death. Much of human behavior is related to the individual's fear of death and his/her unceasing efforts to escape or to control it. "This is the worm at the core of the apple, the constant dread that gnaws at our vitals as soon as we awaken to self-consciousness" (Tageson, 1982, p. 205).

Despite the fact that humanists deal with the basic questions of life and death, there is little humanistic literature dealing specifically with the topics of the structure of grief and with how a counselor can best help a grieving person (Lifton, 1967; May, 1969). This lack of literature is particularly striking because death is such an important part of life and a main focus of humanistic study (May, 1969). Perhaps the topic of death has been denied in psychiatry and psycho-analysis due to emotional resistance

of the investigators and to intellectual resistance because of lack of understanding of these issues (Lifton, 1967).

Another reason for a paucity of humanistic research on death and, more particularly, on the grieving spouse is the tendency of humanists to emphasize living rather than dying (Rogers, 1980). For them, every moment of life is to be experienced to the fullest. In fact, the knowledge that people die makes life itself more meaningful. If a person savors life it is because of the constant threat of non-being, death. Each moment of life becomes more precious when one realizes that existence if finite (Shaffer, 1978).

Finally, perhaps little humanistic research dwells specifically on the problems of the grieving spouse because the problems of the bereaved people are viewed by humanists as being no different from the problems of other people. The death of a loved one is a crisis point in the life of a spouse, but as all other crisis situations, it can be an opportunity for long range growth (Frankl, 1959). "That which does not kill me, makes me stronger" (Frankl, 1971, p. 130). The capacity to confront death in ourselves and our loved ones is a prerequisite for growth (Mahrer, 1978).

So, the humanistic literature on the bereaved spouse is written with a different emphasis than the psychoanalytic literature. Both approaches deal with the topic of death, but the results are distinct. Psychoanalytic writers study

emotional changes in the individual during grief. They attempt to find patterns of similar emotions among grieving people and to discuss the psychic mechanisms which operate during the process called bereavement. They ask "What is happening to this grieving client". The humanist, on the other hand asks, "Why are these things happening?" "What is the meaning of this death?" and "What was the meaning of the life of the deceased?" In other words, "humanists stress the adjective rather than the noun in the human animal" (Severin, 1965, p. xvii).

In summary, the main body of humanistic writing on death is concerned with death as it relates to the nature of humankind (Toynbee, 1963). The real change in death is not the loss of physical body, but the end of the potential for human growth (May, 1958; Rogers, 1980).

For the purpose of this dissertation, four humanistic psychologists who have written on the questions of the meaning of life and death have been chosen as representatives of humanistic thought concerning the problems of the grieving spouse. They also discuss how pain and suffering can be useful as agents that stimulate growth. These humanists are A. Maslow, V. Frankl, R. May, and C. Rogers. Although few specific references to bereaved people are made in the humanistic literature it is clear that counselors can gain insights into problems of a widow or widower by

consulting these works since humanists view all problems in the same way.

Each of the four humanists will now be discussed in turn.

1. Abraham Maslow (1908-1970)

Abraham Maslow was born in the slums of Brooklyn, New York, on April 1, 1908. His father was a Russian Jew who, recovering from an unrequited love affair, wrote to his female cousin in Kiev, asking her to come to the United States to marry him.

They had seven children of which Abraham was the oldest. As the years passed, the family's financial condition improved and they were able to move from cold water flats into better and better homes.

Maslow described his mother as a pretty woman but not a very nice one (Wilson, 1972). She enjoyed having babies, but once a new one was born she would invest all her attention in the most recent baby and ignore all the older children. His father was an energetic man who loved whiskey, women and fighting (Wilson, 1972). These things occupied most of his leisure time so he was rarely at home.

This parental combination was so threatening to Maslow that he wondered in retrospect why he had not become psychotic. Fortunately, a kindly maternal uncle enjoyed the children and took care of the older emotionally abandoned

children. Maslow credits this man with saving his sanity (Wilson, 1972).

Despite this avuncular attention, Maslow was extremely neurotic for the first twenty years of his life. Symptomatically he was depressed, self-deprecating, lonely and resentful (Wilson, 1972).

Not only was Maslow's home life difficult, but his school life was complicated by anti-semetic prejudice in the school. This feeling that people often discriminated against him because of his religion was prominent in Maslow's thinking throughout his life (Lowry, 1979). In fact, he was turned down for some teaching fellowships because he was a Jew. In the last years of his life when he was elected President of the APA, he was surprised and pleased that a Jew could be elected to head this organization (Lowry, 1979).

Maslow always excelled in the academic world despite prejudice on the part of some teachers. One day in high school Latin class, a teacher praised him in front of the whole class and this was a turning point in his life--a beginning of better times.

When Maslow originally went to college it was to study law, as his father directed. Maslow disliked the study of law, never went to class, and subsequently dropped out. Later he decided to return to school and study psychology.

During his college years, Maslow developed a deep emotional detachment for his first cousin, Bertha. In order to separate himself from Bertha and thus avoid marriage for a time, Maslow matriculated at the University of Wisconsin. His plan to remain parted from Bertha failed and they were married in Madison while Maslow was still in school. This marriage lasted until his death in 1970. Bertha Maslow continues to publish her husband's work.

Going to the University of Wisconsin proved to be an invaluable experience for Maslow because he was taught by some of the best known American behaviorists including Clark L. Hull, Harry Harlow, and E. L. Thorndike. Despite this strong behavioristic approach Maslow still considered himself a Freudian (Wilson, 1972).

> Maslow was the first to create a truly comprehensive psychology stretching, so to speak, from the basement to the attic. He accepted Freud's clinical method without accepting his philosophy. Man is driven by sexual urges, dominance urges, territorial urges; but these are only the lower part of the picture (Wilson, 1972, p. 172).

Maslow seemed to be able to take principles from both the Freudian and behavioristic schools and add his own ideas to form a new approach to psychology (Goble, 1971).

Upon graduation, Maslow spent 14 years teaching at Brooklyn College. Bertha thought that his job presented no growth opportunities for Maslow, but he enjoyed his work because he felt that he was contributing something to

society. To a large extent he was working with underprivileged people. One of Maslow's studies of more primitive people was a government grant to study the Northern Blackfoot Indian tribe in Alberta, Canada. Dr. Maslow found these people to be totally lacking in hostility and aggressive tendencies. He found that the children were seldom punished and that they grew up to be free of cruelty. Maslow concluded "that human aggression is the result more of culture than of heredity" (Goble, 1971, p. 13). During this time he wrote his best works (Wilson, 1971) including Principles of Abnormal Psychology (1941) and his landmark work on peak experiences (Maslow, 1959).

From 1951-1969 Maslow taught at Brandeis where he felt unappreciated by the students. Apparently they thought he was boring. Perhaps some students of the 60's found concepts such as self-actualization to be nebulous and irrelevant given the current political and social unrest of that time. Other students tried to have "peak experiences" on a regular basis by experimentation with mind altering drugs or through sexual encounters. This problem was recognized by Maslow who wrote a new preface to the second edition of his book on peak experiences (1974) cautioning that peak experiences were natural experiences which could not be forced by synthetic means.

Maslow so disliked teaching at Brandeis that only his need for money held him in the teaching profession.

Finally, in 1969, he was offered a study grant from a company in California where his program for motivation (Maslow, 1970) had been instituted. He loved the climate and the beauty of the area, but the long years of working 80 hours per week had taken their toll on Maslow's heart. He experienced chronic fatigue all his life and suffered his first heart attack in 1945 at the age of 37. Maslow suffered from such severe anxiety before a speaking engagement that for days after his presentation he would be forced to stay in bed due to nervous exhaustion (Wilson, 1972). After his first heart attack, problems with his heart were complicated by his fear that sexual stimulation would harm his heart. Maslow had very strong sex drives as a young man and he experienced frustration at his inability to meet this physical need.

So, from his childhood, Maslow developed anxieties which he carried throughout his adult life. Additionally, he experienced poor health which was undoubtedly exacerbated by his nervous condition and depression. It is interesting to note that for many years Maslow studied the self-actualized person, who he described as content and self-assured. Maslow must have been looking for the key to relieving some of his own anxieties and neurotic fears. Perhaps he thought that studying these higher motivated people would show him the way to greater peace and health.

Regardless of the reasons for this study of self-actualized people, it is clear that Maslow was a man driven to his work and one who was no stranger to personal suffering in the form of parental abuse and chronic illness.

About 1940, Maslow began his study to find a psychology of the will (1943) which was later published as Chapter 3 of Motivation and Personality (1954/1970).

Maslow had studied the existentialists' picture of normal man which he found to be pathological. Maslow thought that the existential view of "authentic living" consists of living with allusions and fear.

> we need [not] take too seriously the European existentialists' exclusive harping on dread, anguish, on despair and the life, for which their only remedy is a stiff upper lip. This high I.Q. whimpering on a cosmic scale occurs whenever an external source of values fails to work (Maslow, 1968, p. 16).

Maslow felt that the existentialists saw life from only one perspective, the dark side, and that they were blinded by viewing only tragedy. They saw no joy. For Maslow, life is a combination of both tragedy and joy. Both are necessary to life. Tragedy can be therapeutic and therapy works best when people are driven into it by pain (Maslow, 1968).

So, as Maslow asked questions about the meaning of suffering and the meaning of joy (1943) he began to speculate on the importance of studying the whole person. However, he rejected the existential and Freudian approaches

of studying the abnormal and dark sides of life, choosing instead to study the best of people, those who were "self-actualized". Incidentally, to study normal people had always been Freud's unattained goal (Jones, 1957). Maslow thought that the behaviorists too had a narrow view of humankind. So, Maslow created a "third force" in psychology which was an integration of different psychologies aimed at arriving at larger truths (Maslow, 1968).

Maslow as a humanistic psychologist (Severin, 1965; Child, 1973) does not address himself to the problem of grieving, only to a generalized problem of pain. Perhaps this is because Maslow experienced few deaths of loved ones, but he did experience generalized anxiety and illness.

Maslow speculated that making peace with the idea of one's own death makes us appreciate the present more fully Maslow, 1972). "The surf will be here forever and you will soon be gone. So hang on to it; appreciate it; be fully conscious of it. Be grateful for it. You are lucky" (Maslow, 1972, pp. 348-349).

An interesting paradox in Maslow's writing concerning the relationship between life and death is his speculation that "peak experiences" are little deaths. "Peak experiences" are times in our lives when we transcend ourselves. In order to experience this feeling of exhilaration we must first lose our sense of self-consciousness, that is,

we must die to ourselves. So, the highest of experiences, the peak experience can be a little death while at the same time we experience a rebirth in various senses (Maslow, 1972). One could speculate further that actual death is the greatest of all peak experiences which results in a new sensual rebirth.

In summary, Abraham Maslow, a man who had experienced both joy and suffering in his own life, combined existential, behavioristic and humanistic principles to form a "third force" in psychology, humanistic psychology (Maslow, 1968; Goble, 1971). He is credited with shaping humanistic principles into a humanistic psychology (Eysenek & Wurberg, 1972). This new theory seeks to answer questions about the psychology of the will, about how people may live their lives to the fullest so that when death comes, they will be content with their accomplishments (Maslow, 1968, 1970, 1972). Maslow viewed death, the main limitation on life, as a necessary event which forces people to live each day of their lives with a sense of earnestness and purpose.

2. Viktor Frankl (1905-)

Viktor Emil Frankl was born in Vienna, Austria, on March 26, 1905. His father, Gabriel, was a government employee. In 1930, Viktor received an M.D. degree from the University of Vienna. From the beginning of his career Frankl was interested in neurology and psychiatry. On July

18, 1941, he married his first wife, Mathilde, who was murdered in 1945. In 1947 Frankl married his second wife, Eleonore. They have one child, Gabrielle, who was probably named for Frankl's father (Bowden, 1977).

At the same time Maslow (1943) was struggling in the United States to find a psychology of will, Viktor Frankl was dealing with these same issues on a more intimate basis in a concentration camp in Dachau, Austria (Wilson, 1972). Few people have suffered more personal tragedy in their lives than Frankl. He spent three years in various concentration camps during World War II. Upon his release, he learned that his entire family--mother, father, sister, and twenty-four year old wife--had been murdered at Auschwitz. All of his personal property including the manuscript of his first book, later printed and published as the Doctor and the Soul (1955), was stolen by SS guards. He was forced to live as an animal and was stripped of all human dignity. Yet, he managed to survive and to find meaning in his horrible suffering (Frankl, 1959, 1967, 1975). He has since dedicated his life to helping others find meaning in the face of the tragic triad--death, suffering, and guilt (Frankl, 1967).

In the concentration camps, Frankl observed how prisoners dealt with their stress in different ways. Frankl found that those prisoners who had a sense of purpose were able to better deal with tragedy. It seems that physical

health is directly related to a sense of purpose (Frankl, 1971). Frankl gave the example of one prisoner who became convinced that they would be freed on March 30. When it became clear that this would not happen, the prisoner lost hope, collapsed, and died.

In order to find meaning to sustain him during his arduous work schedule at the concentration camps, Frankl spent hours mentally rehearsing how he would lecture in Vienna medical schools about his internment experiences and the psychological effects of imminent death and torture. He tried to reconstruct his book on little scraps of paper which he found around the camp. At some times he was able to be a group leader for therapy sessions with the prisoners, but most of the time he was too mentally distressed to help others (Frankl, 1971).

When Frankl entered the German concentration camp, he was a wealthy 35 year old medical doctor. Upon his release from Dachau at the end of the war, he became a professor of neurology and psychiatry at the University of Vienna Medical School where he stayed until 1970. During these years, Frankl fulfilled many of the daydreams which had sustained him during his concentration camp experience. He rewrote the book, The Doctor and the Soul (1955), which had been taken from him by the Germans. He lectured about his camp experiences and wrote several books including: Man's Search for Meaning (1971), Psychotherapy and

Existentialism (1967), The Will to Meaning (1969), The Unconscious God (1975), and The Unheard Cry for Meaning (1978).

Frankl's influence was so profound that he is credited with forming the third Viennese school of psychotherapy. According to Frankl (1976) the first school begun by Freud stressed objectivity. This objectivity tended to remove peoples' humanity and to treat them as objects. The second school, the Adlerian approach, centered on courage and attempts to encourage the client. The third school, Frankl's logotherapy, stresses responsibility and the humanistic nature of people (Frankl, 1976).

Logotherapy is "a psychotherapy which not only recognizes man's spirit, but actually starts from it... In this connection, logos is intended to signify 'the spiritual' and, beyond that, 'the meaning'" (Frankl, 1965, p. xi). People live in three dimensions: the physical, the emotional, and the spiritual or intellectual. Logotherapy is primarily concerned with the spiritual dimension of humankind.

While still a professor at Vienna, Frankl spent two years as a visiting professor in the United States. In 1950 he spent one year at Harvard University and in 1961 he taught at Southern Methodist University. In 1970, Frankl was a Professor of Logotherapy at the United States International University. Because of Frankl's wide popularity in

the United States as well as in Vienna, all his books were written and published in German and in English.

Frankl's three major insights (Wilson, 1972) are as follows: (1) Physical health is directly related to a sense of purpose. Boredom and despair make one vulnerable to physical and mental illness. (2) Purposive consciousness depends upon an attitude of mind rather than upon definite goals. An attitude of optimism can make the most painful task bearable. (3) The "law of reverse effort" can be used in counseling to help people attain their goals. Frankl has named this technique "paradoxical intention" (Frankl, 1967, 1978).

Of the four humanistic writers chosen for this study, Frankl discusses death and tragedy most frequently. Undoubtedly this is due to his great personal suffering and need to find meaning in life and death. All of Frankl's books discuss the meaning of life and death (e.g., Frankl, 1965, 1969, 1971, 1978).

Frankl is also outspoken in his open acknowledgment of God (Frankl, 1965). He has stated that it is self-evident that there is a God or at least some overmeaning. This gives life meaning and makes our everyday tasks meaningful. Meaning is not always readily apparent. Sometimes sufferers must be patient in their search to find meaning rather than immediately giving in to suicide or drugs (Frankl, 1975).

The value of death is that it gives a degree of finiteness to life. If our lives went on forever, we could postpone every action.

> But in the face of death as absolute finish to our future and boundary to our possibilities, we are under the imperative of utilizing our lifetimes to the utmost, not letting the singular opportunities--whose 'finite' sum constitutes the whole of life--pass by unused (Frankl, 1975, p. 73).

Suffering also has a purpose. It arouses a tension which makes us aware of how things should not be. The purpose of suffering, as in the death of a spouse, is to keep people from apathy. It prevents humankind from emotional death. "As long as we suffer we remain psychically alive" (Frankl, 1965, p. 125). Further people become stronger as they suffer.

In summary, Viktor Frankl, prior to his concentration camp internment, had begun his professional psychiatric career which included his study of peoples' need to see order and a purpose to the universe and to their lives and suffering. Frankl's theories were put to the test during his three years as a war prisoner. His attitudes and faith in God gave him the strength to survive. Upon his release from the camps, he set out to tell others about the answers he had found when he was a part of this vast experiment on suffering and the human spirit.

3. Rollo R. May (1909-)

Rollo May is another humanist who grew emotionally

and individually from a tragic experience. He was born in Michigan in 1909 to Methodist parents. His mother named him Rollo after "Little Rollo", a perfect young gentlemen from a set of character building books for children. Needless to say, May was never able to live up to the Victorian model of perfection that his mother expected him to emulate. Feeling unaccepted and inferior, May remained a loner throughout his childhood.

A major turning point in May's life came in the early 1930's. He contracted tuberculosis at a time when there were no drugs to cure it. The only treatment was bed rest. So, having been given a 50-50 chance for survival, May lay in a hospital bed for a year and a half. Only periodic x-rays showed if the disease was progressing or not. This experience gave him, "a depth that goes far beyond mere theories or concepts and makes them seem absurdly superficial" (May, 1969, p. 3).

During this time May began to appreciate the existentialists and their writing such as The Plague by Camus (1948), The Tragic Sense of Life by Unamuno (1954), The Flies by Sartre (1943), and The Courage to Be by Tillich (1952). These books all show contemporary man's view of his struggle with the world just as May had struggled with tuberculosis.

Tuberculosis caused May to increase his contemplation of several humanistic issues including (1) the meaning

of anxiety (1950), (2) the importance of finding the positive side of tragedy including death (1969), (3) the relationship between sex and death (1969), and (4) the relationship between death and love (1969).

The Meaning of Anxiety (1950), May's doctoral dissertation, held wide appeal for the layman. He described two types of anxiety, neurotic and free floating anxiety. Neurotic anxiety comes from an unjustified fear that one's ego structure or "centeredness" is being attacked. This neurotic anxiety is always destructive both physically and emotionally.

On the other hand, free-floating anxiety can be beneficial and can lead to constructive activity (May, 1950). This anxiety is a result of man's inner need for individual and social development. May felt that this free-floating anxiety enabled him to fight to overcome his tuberculosis. It can cause people to strive to live up to their potentials and to take responsibility for their actions.

A second humanistic issue discussed by May (1969) is the importance of finding the positive side to life despite tragedy such as the death of a loved one. May cites the example of William James who suffered from ill health and depression during his 20's and 30's. James' depression was so severe that he frequently considered suicide. One day he made a conscious decision that life was worth living. "My

first act of free will is to believe in free will" (Allen, 1967, p. 168). At that point, James decided to live constructively, to see life in a positive way despite his mental and physical problems.

Often tragedy can lead one to find the positive side to life (May 1969). May's life is a perfect example of how tragedy can make one stronger. Because of his battle with tuberculosis, May had time to concentrate on the psychological issues which have made him a prominent force in modern psychology. Largely due to his illness, May has become the most prolific writer on the topic of existential psychotherapy, a humanistic approach to psychotherapy (Moritz, 1973).

A third theme of May's is the relationship between death and the sex act (May, 1969). Intercourse is an imitation of the act of dying. During orgasm the self is surrendered for a short time. The ability to abandon oneself is necessary for an orgasm to occur. This surrender of personal awareness is similar to what happens, on a larger scale in the act of dying. In death the self is totally given up.

A fourth theme of May's is the relationship between death and love (May, 1969). It is a paradox that love gives us an awareness of death and death gives us an increasing awareness of life. "Death and delight, anguish and joy, anxiety and the wonder of birth--these are the warp and woof

of which the fabric of human love is woven" (May, 1969, p. 100).

Only we humans have an awareness of our own death--an existential nothingness. This existential nothingness is similar to apathy. Apathy is the opposite of love, not hate (May, 1969). To feel hate is to recognize the presence of another person and to feel some emotion toward that person. Apathy, on the other hand sees through people as they were not present (Buscaglia, 1982). It is preferable to be hated than to be regarded with total indifference.

When people love others, they are immediately faced with the dilemma that to love someone means to risk the heartbreak of certain separation at some point in life. Every positive force in life such as love, has a negative aspect such as death and separation. However, the negative side of each positive force merely increases the value of the positive side. So, the value of love is increased because of the knowledge that separation will someday occur.

May's writings show the influence of other humanists. He had studied under Paul Tillich in 1938 to earn a Bachelor of Divinity degree. May did not want to become a minister at that time, but he did wish to ponder questions concerning the meaning of life and death. May was also influenced by Frankl whose Existence (1938) he translated from German. Maslow read May's translation of Frankl (Wilson, 1972). In short, these humanists were aware of the

work of the others, and generally respected the scholarly efforts of their contemporaries.

In summary, Rollo May is a humanistic psychologist whose search for the answers to questions concerning the meaning of life and death intensified during his own life-threatening battle with tuberculosis. He has discussed how the awareness of death--an existential nothingness--is a source of anxiety. However, this free-floating anxiety can be a positive force as it drives people to act and to live in the present rather than waiting to live in a future which may never come. May has also concluded that people have freedom of choice even in the face of tragedy for they can choose how they will respond to any given situation. Further, May states that people are responsible for the effects of their own actions (May, 1969, 1972).

People do not begin to live until they face the fact that they live by choice and could choose to kill themselves at any time. Since people are free to die, they are also free to live (May, 1952).

When people choose to live then they (1) accept responsibility for their own lives, (2) become self-disciplined. Instead of being ruled from the outside, they become ruled by themselves. "Discipline is necessary for the sake of the values [they] wish to achieve" (May, 1953, p. 173).

4. Carl R. Rogers (1902-)

Carl Rogers was born in Oak Park, Illinois, in 1902. He is best known as the founder of client-centered therapy (Rogers, 1951). This therapy is based on a person-to-person type of counseling where the client has control of the content, pace, and duration of therapy.

Rogers was raised in an affectionate, albeit strict religious family. At the University of Wisconsin he enrolled in a program to become a Protestant minister. However, on a Christian ministry trip to China in 1922, he realized that ways of religious thinking other than his own could produce honest and hard-working people. This was a turning point for Rogers who then became more open minded.

In 1924, Rogers entered the liberal Union Theological Seminary in Chicago. He was concerned with the questions on the meaning of life and death but he could not adhere to any one religious dictate or doctrine. So, Rogers changed his major from theology to guidance and took his Ph.D. at Columbia University Teachers College where his main interest was child guidance (Moritz, 1962).

In 1940, he became a teacher of counselors at Ohio State University. Here Rogers began to develop a different, and hotly debated new theory of humanistic psychotherapy (Rogers, 1954). As a Professor of Psychology at the University of Chicago, he practiced his methods which he reported in Psychotherapy and Personality Change (1954). In his

major work, On Becoming a Person (1961), Rogers suggests that even the most disturbed person is capable of moving in a positive direction with the help of an empathetic therapist.

Although Rogers has written extensively on the topic of interpersonal relationships (Rogers, 1951, 1961, 1977), no mention is made of the effect that the death of a husband or wife can have on a surviving partner. In fact, Rogers contrasts with Maslow and especially with May and Frankl in his lack of preoccupation with death. He speaks of life rather than death with the exception of a recent article which discusses his old age and imminent demise (Rogers, 1980). Compared to May and Frankl, Rogers' life appears to have been relatively crisis free. He married a childhood friend who is still living and he had two healthy children. Unlike Frankl, his war experience was not tragic. Rogers served as a psychological consultant to the Army Air Force during the war years and never saw combat. Unlike May and Maslow, Rogers' health has been relatively good and he still walks four miles a day.

Perhaps Rogers' less tragic life experiences account for his lack of preoccupation with death as in the work of Frankl. Of the four humanists chosen for this dissertation, Rogers most emphasizes people's innate goodness and constructive drives.

If Rogers does not deal with the problems of the bereaved client, why then is he included in this discussion? First, he is included because of his contribution to humanistic psychology, that of developing a humanistic psychotherapy, client-centered therapy. Rogers turned the theory of humanism into a working plan for helping clients (Rogers, 1951).

Secondly, he is included to illustrate the diversity of humanistic thinking. Death and life are inseparable in humanistic thought. Death gives meaning to life and, conversely, life gives meaning to death. Rogers has chosen to speak mainly of living. Frankl, on the other hand, has devoted a great deal of writing to the meaning of death. Both view the same topic from a different perspective; their perspectives being colored by their own personal experiences.

All four humanistic theorists have considered the question of life and death in an attempt to reach an intellectual understanding of how lives may be lived more fully in order to fulfill human potentials. However, it can be seen that in this chapter more pages have been devoted to Frankl, Maslow, and May than have been left for a discussion of the life of Carl Rogers. This inequity reflects the fact that much more biographic information is available for Frankl, Maslow, and May than is available for Carl Rogers. Maslow's diary has been published in two volumes (Lowry,

1979) and Frankl has detailed his personal experiences in several books (e.g., Frankl, 1955, 1959). In other words, the coverage given to each of these four men reflects the amount of available biographical literature. The remainder of this chapter will deal with their conclusions and suggestions for all men and women.

Humanistic Description of the Mourning Process

This section, which describes the mourning process, is organized around the following questions:

1. What are the characteristics of the normal grieving spouse?
2. Do these characteristics appear in stages? What are these stages?
3. How long does the grieving process last?
4. What is the difference between normal and abnormal grief?
5. Is grief an illness?

The answers to these questions will be taken mainly from the works of Frankl, May, Rogers, and Maslow.

1. What are the characteristics of the normal grieving spouse

In general, humanistic psychologists view the grieving client as they would any other person who has come to a crisis point in his or her life (Carkhuff, 1969). That is, the person is at a turning point when one can grow from the

experience or deteriorate physically, emotionally, and intellectually. Growth can arise from pain and suffering.

Specifically, the bereaved spouse has three tasks to accomplish:

a. To accept the pain of suffering (May, 1953, 1958; Maslow, 1968)

b. To become strengthened by the suffering (Frankl, 1967, 1975; May, 1969; Edwards, 1979; Bugental, 1967)

c. To find meaning in death, both of the deceased and in his or her own death (Frankl, 1965, 1975, 1978; Maslow, 1970; May, 1953, 1969; Rogers, 1980)

These three tasks will now be discussed more fully.

a. <u>To accept the pain of suffering</u>

In order to grieve in a constructive way, people must be willing to accept the pain of the separation rather than trying to escape it. The pain of separation is the pain of adjusting to life without the deceased person. Much human suffering occurs in an attempt to escape death--that of others and of ourselves (May, 1958).

Grief and pain are sometimes necessary to the growth of a person. Friends of grieving people must learn to stop trying to automatically protect people from it.

> Not allowing people to go through their pain, and protecting them from it, may turn out to be a kind of

> overprotection, which in turn implies a certain lack of respect for integrity and the intrinsic nature and future development of the individual (Maslow, 1968, p. 8).

"Until two or three generations ago, widows' weeds were worn by women and black armbands by men to announce, in effect, that the wearer was grieving . . . these markers, and the sympathy they elicited, helped the person to experience grief" (Dempsey, 1977, p. 153). Today people are encouraged to go on as if nothing had happened. They are encouraged to ignore the tragedy.

The key to accepting this pain is courage. "Courage is the capacity to meet the anxiety which arises as one achieves freedom" (May, 1953, p. 224). Courage is needed at every crisis point in life such as first going to school, adolescence, getting married, family crisis, the death of a spouse, and ultimately one's own death.

Also needed is a vision of the future which gives hope to the bereaved person. Frankl (1959, 1971) found that only those prisoners with an eye to the future were able to endure the tortures of the concentration camp.

b. <u>To become strengthened by the suffering</u>

The death of a loved one is clearly a painful time, but like all crisis situations, it can be a time of growth (Frankl, 1967; May, 1969).

> Through the right attitude unchangeable suffering is transmuted into a heroic and victorious achievement . . . Everything depends on the right attitude in the

> same way and manner as in the case of his suffering. The difference lies in the fact that the right attitude is, then, a right attitude to himself (Frankl, 1967, p. 90).

According to Frankl (1967), there are three roads to growth: love, work, and suffering. Suffering consists of the tragic triad--guilt, pain, and death (Frankl, 1967). Clearly, the death of a loved one is a time of great personal loss and suffering. Frankl (1965, 1971) learned from his experience in the concentration camp that the death of a spouse and/or other loved ones can open a new door to unlock personal strength heretofore hidden. New insight into life's meaning and mysteries may also be gained. Personal empathy may increase. Widows and widowers must take the pieces of their former lives, salvage what they can, and create new lives. However, after working through such a crisis, the survivors are stronger than before because they now realize that they have the courage to handle any situation (May, 1975).

When people fall in love and marry, it is inevitable that, at some point in time, they will be separated. It is a great paradox of love that love means to open oneself to the possibility of grief and sorrow (May, 1969). To love is to risk pain and the greatest love is always accompanied by the knowledge of the imminence of death. "Some--perhaps most--human beings never know deep love until the experience, at someone's death, the preciousness of friendship, devotion, and loyalty" (May, 1969, p. 102). Love is

enriched by our sense of mortality and is made up of the realization that this person will not exist forever.

Often suffering strengthens a couple's love for each other. Edwards (1979) describes how her father and mother became closer than ever before when her father suffered with cancer during the last year of his life. To paraphrase what La Rochefoucauld (cited in May, 1969) once remarked with regard to love, one might say that just as a small fire is extinguished by the storm whereas a large fire is enhanced by it--likewise a weak love is weakened by predicaments and catastrophes whereas a strong love is strengthened by them. Thus, spouses may never really appreciate the depth of love they felt for their marriage partners until they are gone. That is, the death, and suffering prior to death, may enhance their love. That love then becomes crystallized in time and space (Frankl, 1975). In other words, although a spouse may die, their love does not necessarily die and may, in fact, be strengthened.

According to some religious humanists such as Frankl, death of a loved one may increase religious faith (Severin, 1967; Frankl, 1975). In every person there is a deep religious sense which may emerge only at the depth of despair (Frankl, 1975). Frankl (1975) gives the example of a student, confined in a mental hospital, who was treated like an animal--totally abandoned for a time, then given shock treatment, insulin shock, and drugs. Finally he had a

sense of being with God. He knew that he was not really alone. The student felt that there must be some reason why he had survived, that someone [God] must want him to live to accomplish some task or goals. He developed a sense of mission and rapidly improved. The student was released from the hospital and went on to live a purposeful life.

Frankl (1975) found from his Auschwitz experience that faith can be strengthened by adversity. Of those who lived through the concentration camp experience, more came out with a stronger faith than those who had lost their belief in God.

Although Rogers (1980), Maslow (1971), and May (1953) do not emphasize the importance of God in giving one held through a crisis, they do stress the necessity of feeling that there is order in the world and that people need to live up to their potentials. All people should become the best that they are able (Severin, 1967).

a. <u>To find meaning in death, both of the deceased and his or her own death</u>

Humanists tell us that a widow or widower, in order to grieve fully, must come to an intellectual understanding of why their spouse died. Frankl (1975) gave the example of a fellow physician who had grieved for many years for his deceased wife. Frankl was able to assuage his friend's grief by painting a picture of how difficult it would have been for the deceased wife had her husband preceded her in

death. She was a very dependent person who would have been devastated had her husband died first. Looking at it from this perspective, the doctor was able to find comfort in the fact that he, instead of his wife had to endure the pain of separation. The physician was then able to lay aside the grief and begin a normal life again.

Frankl (1975) gave another example of an American medical student whose good friend committed suicide because he could find no meaning in life, and therefore, no reason to live. The surviving friend dedicated his life to helping people who were in distress as his friend had been. "I have found meaning (despite my deep sorrow and guilt) in my friend's life and death" (Frankl, 1975, p. 97).

If a surviving spouse is unable to find meaning in the tragedy of the partner's death, he or she lives in an existential vacuum (Frankl, 1975). The term existential vacuum, "represents what could be called the collective neurosis of our time . . . [those] who complain about the meaningless of life . . . are beset by that inner void" (May, 1967, p. 17). Existential vacuum is similar to the phrase "epistemological loneliness" coined by David Bakan (1956) to express man's alienation from his world (May, 1967). This existential vacuum presents itself as a state of boredom. In the long run, boredom causes more psychological problems than anxiety (Frankl, 1971).

How people find meaning in the death of a spouse is directly related to the meaning they find in their own life and death. The death of a loved one can trigger anxiety and self-doubt (Maslow, 1970) not only because it puts the survivors in new situations but because it reminds them that they too must die. In order to accept the death of loved ones, people must confront the idea of their own deaths or else live with undefined anxiety and self alienation. This means that death must be accepted as an integrated part of life (Feifel, 1969; Rogers, 1980).

Those people who have faced the idea of their own death understand that death serves an important function for the living. "The possibility of death jars us loose from the treadmill of time because it so vividly reminds us that we do not go on endlessly" (May, 1953, p. 271). Death is a limitation which causes the present to be taken seriously.

Attempts to avoid thoughts of death can lead to severe mental problems. For example, schizophrenics may try to hold off death by not living. They reason that, "if living leads inevitably to death, then death can be fended off by not living" (Feifel, 1969, p. 60).

Carl Rogers views his own death as a new experience--an experience to be received openly. Since he has lived his life as fully as he could, and since he will leave his ideas behind him, Rogers can accept death as a natural end. He has no deep fear of death (Rogers, 1980). Death

could, in fact, be a transformation into a realm of deeper potential (Mahrer, 1978; Rogers, 1980).

May (1953) gave the following example of how the imminence of death can be a positive motivating force in a person's life. A young English writer could never publish his work. When he was in the war and fearful of dying every day, he threw out the prescribed form of writing which he had been using. Rather than writing according to a formula, he wrote according to his own integrity. Then he was able to sell his writing. In the following paragraph May explains the intellectual change which the writer underwent so that he could write in a more natural style.

> To grasp what it means to exist, one needs to grasp the fact that he might not exist, that he treads at every moment on the sharp edge of possible annihilation and can never escape the fact that death will arrive at some unknown moment in the future. Existence, never automatic, not only can be sloughed off and forfeited but is indeed at every instant threatened by non-being. Without this awareness of non-being--that is, awareness of the threats to one's being in death, anxiety, and the less dramatic but persistent threats of loss of potentialities in conformism--existence is vapid, unreal, and characterized by lack of concrete self-awareness. But with the confronting of non-being, existence takes on vitality and immediacy, and the individual experiences a heightened consciousness of himself, his world, and others around him (May, 1967, pp. 47-48).

Aside from making people aware of the finiteness of life, death has additional meaning. A person does not become a reality at birth, but rather at death (Frankl, 1976; Rogers, 1980). When people die, they are crystallized in time and fully created. Dead people can no longer change or become. They are frozen as the people they have created.

In other words, when people die, they can no longer change. They have formed their own heaven or hell on earth and when they die, they become what they have created. Frankl states the paradox that, "man's own past is his true future. The living man has both a future and a past; the dying man has no future in the usual sense, but only a past; the dead, however, 'is' his past. He has no life, he 'is' his life" (Frankl, 1975, p. 112).

In summary, the surviving spouse who is grieving normally has three tasks to accomplish. These tasks are the same as those of any other person enduring suffering. The tasks are: (a) to face the suffering with courage and self-confidence, (b) to emerge a stronger person because of the suffering, (c) to find meaning in death (and suffering) of others and of ourselves.

Death is a necessary part of life because it instills in people a need to live in the present. Also, death crystallizes people in time. They are no longer merely "becoming", they "are". Death must be viewed as an integral part of life (Miyuki, 1978).

2. Do these characteristics appear in stages? What are the stages?

Humanists do not write about grief in terms of stages. They do not attempt to dissect grief to find its parts. In fact, humanists do not isolate the grieving spouse as a subject for study. As previously mentioned,

bereavement is viewed by humanists as being no different from any other crisis situation (Maslow, 1968). The death of a spouse may be a time for growth or deterioration (Carkhuff, 1967). It is up to the survivor to find meaning in the death and to finally perceive it in as positive a way as possible (Frankl, 1965).

3. How long does the grieving process last?

None of the four humanists studied herein discuss the length of normal grieving. Frankl (1975) gives one example of a man who grieved for years when his wife died. Frankl thought that several years was too long a time for normal grief, but he offers no suggestion as to how many years is too long. Again, the grieving client has not been isolated by the humanists for study. They have not tried to find a pattern for the duration of normal grief.

4. What is the difference between normal and abnormal grief?

The humanistic writers discussed herein mention four ways in which abnormal grief may be manifested. In normal grief these four symptoms do occur, but in abnormal grief the symptoms last a longer time and are more intense. These way are:

a. complete abandonment of time and energy to mourning

b. total absorption with oneself

c. acceptance of unnecessary suffering

d. blocking of sorrow

These four neurotic activities will now be discussed in turn.

a. Complete abandonment to mourning

In folklore and in fact, people have been found to give themselves so fully to grief that they die (May, 1950). As early as 1750, public health records listed grief as the cause of several deaths (Parkes, 1972).

Certain mourning customs, such as wailing for days after the death of a loved one, seem to exacerbate neurotic mourning by encouraging total surrender to it. They attempt to, "alleviate the pain of loss by acutely intensifying it and inducing complete abandonment to it" (Horney, 1964, p. 267). This is a masochistic way of mourning which leads to neurosis.

b. Complete absorption with oneself

Often during the grieving process, depression and withdrawal occur. This problem is often due to a feeling that life no longer has purpose or meaning (because the deceased spouse is no longer there (Frankl, 1975). This turning in to oneself is neurotic and causes a person to become less human. Human existence which is not neurotic is always directed toward something or someone other than oneself (Frankl, 1975). "The more one forgets oneself--

giving oneself to a cause or another person--the more human he is" (Frankl, 1975, p. 79).

Total absorption with oneself may also be caused by fear of death (May, 1958; Frankl, 1975). Death is a symbol and manifestation of people's fear of non-being. Further, fear of non-being means more than fear of death. It also refers to the threat of non-being in the physical and intellectual senses. The real fear is that life is meaningless--that our existence is meaningless (May, 1958).

According to Maslow and Frankl, neurosis is a passive state (Wilson, 1972). It is noise without action. It is like a car sitting in idle, making noise, but not moving. Neurotic fear of death is the brake which does not allow a person to move forward with creative activity (May, 1950).

Neurotic fear of death can become so overwhelming that it may effect every part of one's life. For example, William Randolph Hearst was so anxious, despite his vast fortune, that he never allowed the word "death" to be spoken in his presence (May, 1953). Obviously, such attempts to avoid death only increase anxiety concerning it (May, 1953; Frankl, 1965).

Of course, not all fear of death is neurotic. When the fear motivated us toward activity it is not neurotic (May, 1950). The "free-floating anxiety" created by fear of death often causes us to accept responsibility for our lives and to live creatively (May 1950, 1975). Much of the

creative philosophical thinking of humankind can be directly attributed to the individual's fear of death (Toynbee, 1963).

So, total absorption with oneself which may occur during grieving is considered to be an abnormal fear of death. Healthy human behavior is not self-centered, but rather focuses on something or someone outside of oneself.

c. Acceptance of unnecessary suffering

Sometimes during grieving, the survivor accepts more suffering than is necessary (Frankl, 1975). It is important that people accept what they are unable to change, and change what they can. For example, to continue to mourn long after the spouse has died is to accept unnecessary suffering. Accepting pain when one does not have to is masochistic (Frankl, 1975). More specifically, although some surviving spouses would like to date again, they often hesitate to seek new companions years after their former partner died. They sometimes feel that interest in a new person and beginning to be happy again is a betrayal of the deceased spouse. In reality, this is unnecessary suffering.

Another way to suffer unnecessarily is to worry about problems which are not real. Self-actualizers have fears, anxieties, and frustrations, but all of these center on real, not imaginery problems (Wilson, 1972).

So, the bereaved spouse must be concerned only with actual problems as they occur, not becoming overwhelmed by

possible and, as yet, non-existent problems.

d. Blocking of sorrow

Blocking of sorrow is another way in which abnormal grief may be presented. Unfortunately, attempts to avoid the pain of grieving only result in increased pain later and possibly in serious mental problems (Frankl, 1965).

Sorrow is a part of life just as joy is. To try to avoid trouble and sorrow produces an emotional death--a denial of part of life. "Only under the hammer blows of fate, in the white heat of suffering, does life gain shape and form" (Frankl, 1965, p. 128).

"Death--that paradigm of the irreversible event--is not wiped off the slate by being pushed out of consciousness, any more than when the mourner himself takes refuge in absolute non-consciousness--the non-consciousness and the responsibility of his own death" (Frankl, 1965, p. 127).

Modern funeral preparations attempt to mask the reality of the death. The corpse is embalmed and made up to look alive. People remark at the wake on how "good" the deceased person looks. The death is not talked about and psycho-religious messages tell us that the less grief we experience the better (May, 1969). All of these cultural practices and attitudes make an open expression of grief more difficult and thereby encourage the unhealthy practice of blocking sorrow.

In summary, unhealthy grieving is characterized by complete abandonment of time and energy to mourning, total absorption with oneself, acceptance of unnecessary suffering and/or blocking of sorrow. All of these are neurotic conditions which should be discouraged by society in general.

5. Is grief an illness?

Humanists do not refer to grief as an illness. In fact, they see any situation, no matter how bleak as an opportunity for growth. Frankl states that even his "tragic triad"--pain, guilt, and death--may be turned into something positive (Frankl, 1975, p. 125).

> Caught in a hopeless situation as a helpless victim, facing a fate that cannot be changed, man still may turn his predicament into an achievement and accomplishment at a human level. He thus may bear witness to the human potential at its best, which is to turn tragedy into triumph. The measure of a man is the way he bears up under misfortune (Plutarch cited in Frankl, 1975, p. 125).

The humanists mentioned in this dissertation attempt to see all situations in the best possible way (May, 1975). They try to dwell on the positive aspects of life, rather than on the negative (Rogers, 1980). Therefore, they would deplore the use of the term "illness" in connection with a person who is going through the grieving process.

To summarize the humanistic section on the process of grieving, humanists describe the mourning process in terms similar to those which apply to any other crisis situation. The grieving spouse must meet the challenges of

accepting the pain of separation, finding meaning in the tragedy, while at the same time becoming stronger emotionally.

Humanists do not discuss stages of grief or length of the normal grieving process. They do, however, outline four neurotic manifestations of grief which include: complete abandonment of time and energy to mourning, total absorption with oneself, acceptance of unnecessary suffering, and blocking of sorrow. Trying to avoid the pain of the loss of a spouse merely exacerbates the discomfort.

Finally, humanists never refer to grief as an illness. Rather it is a normal experience of life which should be embraced as one accepts joy. To feel pain is better than to feel nothing (Buscaglia, 1982).

Goals of the Humanistic Grief Counselor

Humanistic counselors encourage self-actualization in their clients (Severin, 1965). The different humanists use slightly modified terms to describe people who have reached their potential. Rogers (1961) refers to the "fully functioning" person. Maslow (1972) speaks of the "self-actualized" person who possesses "B values". Frankl says existence is dependent on "self-transcendence". "Only to the extent that someone is living out his self-transcendence of human existence, is he truly human or does he become his true self" (Frankl, 1978, p. 35). And May (1958) speaks in terms of "becoming".

Despite different terminology, the idea remains the same--the primary goal of the humanistic counselor is to help people to be the best that they can be, to lead their lives to the fullest (Frankl, 1965, 1971; Rogers, 1961; May, 1967; Maslow, 1968).

Additionally, the counselor helping the bereaved would have three added goals:

a. To help clients learn to accept suffering

b. To help clients find meaning in their suffering

c. To help clients to get outside of themselves

These goals will now be discussed in turn. How these goals will be accomplished will be outlined in the "Process of Counseling" section which follows.

a. <u>To help the client learn how to accept suffering</u>

One goal of the therapist is to help suffering people stop trying to avoid pain and to accept it (Frankl, 1965). As previously mentioned, to attempt to run from a problem only makes it worse. For example, when a graduate student, Mrs. L., was five years old her father died. Rather than tell the child that her father was actually dead, the mother told her that the father had merely gone away. The little girl assumed that her father had left her and began to look for him. They moved to a new town and Mrs. L., at 10 years old, found a man whom she believed to be her father. After a time, her mother told her that the

new man was not her father and that he was actually dead. Today at 26, Mrs. L. is still unable to talk about her father and she still catches herself looking for him.

Clients must understand that they are strong enough to handle pain (Buehler, 1967). Each person has enough inner strength to survive a tragedy or loss. On the other hand, running away is, in the final analysis, more destructive than facing the problem.

b. To help clients find meaning from their suffering

As previously mentioned, every situation has the potential of helping a person toward self-actualization (Frankl, 1965; May, 1953; Maslow, 1968; Rogers, 1980). Even in the case of incurable disease or suffering, meaning can still be found. It is the role of the therapist to facilitate this. The therapist encourages the client to have hope in the future and to feel motivated to go on living (Frankl, 1967). Even the dying can find meaning in suffering. A young woman who was dying at Auschwitz told Frankl that she was grateful for her difficult struggles because, "In my former life I was spoiled and did not take spiritual accomplishments seriously . . . This tree here is the only friend I have in my loneliness" (Frankl, 1971, p. 109).

Further, counselors should recognize that they have a responsibility to live as best they can so as to model behavior for their clients (Frankl, 1965). This

responsibility includes living each moment to the fullest. Counselors convey their attitudes toward life to their clients through responses and behavior during the therapy session (Carkhuff, 1969). More specifically, a counselor who is apathetic and disinterested in the client presents the unspoken message that the client and the present moment are not important. This is not a desirable role model for the client. In other words, a personal goal of humanistic counselor is, "to convert an unconscious 'potentia' into a conscious 'actual', but to do so for no other reason than to restore it eventually as an unconscious 'habitus'" (Frankl, 1965, p. 38).

c. To help clients to get outside of themselves

A goal of the grief counselor is to help the client make positive choices each day (Maslow, 1971). During a period of grieving, it is especially difficult to act in a constructive way. More specifically, some bereaved people become very depressed, not getting out of bed until noon. They may refuse to even wash themselves or to get dressed. The temptation remains strong for bereaved people to pull inside themselves, to draw away from the world which has given them so much pain. Yet, it is extremely important that the pain does not prohibit these people from experiencing life (Maslow, 1972).

Process of Humanistic Grief Counseling

A review of the literature did not disclose at what critical point grief counseling is needed. Since grief is a normal process, according to the humanists, it would be a logical conclusion that most humanists would not advise a person who is grieving normally to seek counseling. Grief counseling would then be reserved for those showing abnormal symptoms as outlined in a prior section of this dissertation (see pages 54-57).

In humanistic grief counseling what is the essence of the relationship established with the client? The therapeutic relationship is the key to change (Rogers, 1951). Only within the experience of an understanding relationship can the individual's "self process" take place (Gendlin, 1962). The "self process" is the integration of a person's behavior and feelings (Buhler, 1967). The psychotherapeutic encounter is a "synergistic relationship" (Maslow, 1962), "a shared experience" (Bugental, 1967) which provides the facilitative environment necessary for change.

Humanists do not mention any unique aspect of the therapeutic relationship which must exist between the therapist and the bereaved client. However, voluminous literature on the general importance of the counseling relationship exists (Rogers, 1951, 1961). This knowledge could be adapted to dealing with any client, including the bereaved.

For Rogers (1951) the key to constructive change is the bond which forms between the therapist and the client. The positive regard that the therapist has for the client comes through in the counseling session and the client's self-esteem grows. As a new self-image is conveyed through the eyes of the therapist, the client's ability to change in a positive way grows.

How is information gathered? In other words, how is client intake conducted? In humanistic counseling, intake is not always necessary because the problems of all people are the same (Frankl, 1965, 1967; May, 1977). Despite the particular problems that the bereaved people may be experiencing at the moment, the same universal issues and tasks face all people. To reiterate, these issues are: to become strengthened by suffering, love and work (Frankl, 1967, 1975; May, 1969; Edwards, 1979; Bugental, 1967); to accept suffering as well as joy (May, 1953, 1958; Maslow, 1968); and to find meaning in life and death, constructively acting on that meaning. People must all accept responsibility for their lives and act on that impetus.

To help clients find meaning in their despair does not require taking a lengthy case history. For example, once Frankl (1971) was speaking at a U.S. prison on the importance of responsible action under difficult circumstances. During the speech, the warden asked Frankl to address remarks to a man, sentenced to die in the electric

chair the next day, who was listening over the public address system. Frankl took up the challenge, explaining to the man how there could be meaning in suffering. Frankl explained how it was never too late to become a responsible, courageous person. Although the prisoner had no choice about whether he lived or died, he could choose "how" he would die. He could accept the challenge bravely, being an example of courage for other people. The dying prisoner could give himself the gift of dignity.

Apparently Frankl's talk to the prisoner did help the man because, hours before his death, he wrote to Frankl, thanking him for turning his previously wasted life around. In the face of imminent death, a murderer was able to experience personal growth and purpose.

So, although learning about a client is helpful (Rogers, 1951, 1961), the basic issues of all humans remain the same. The challenges of life may differ in incidental ways, but the life tasks of all people are constant.

How do clients gain insight into their behavior? In order for bereaved clients to grow, they must examine their behavior and attitudes by asking themselves questions such as: What positive action can I take so that my spouse did not die in vain? Am I afraid of my own death? Am I using my suffering as an excuse for not taking responsibility for my own life? How can I learn from this tragedy and become a better person? Have I allowed myself to experience the pain

of suffering or have I hidden from it? Have I continued to live, or did I die with my spouse? Am I an example of courage to others?

The therapist can gently lead the clients through such questions as these. As the clients explore their attitudes, the therapist can encourage them to take paths toward self-actualization.

No one can tell another what the meaning of life is, for each person must figure it out for himself or herself (Frankl, 1968). Counselors cannot give meaning to their clients. Teachers cannot give meaning to their students. "What they may give, however, is an example, the existential example of personal commitment to the search for truth. As a matter of fact, the answer to the question, "What is the meaning of life?" can only be given out of one's whole being--one's life is itself the answer to the question of meaning" (Frankl, 1965, p. 129).

Conversely, teachers or counselors could transmit their own existential vacuums by attitudes and actions which are cynical, bored or defeated. Teachers and counselors have the responsibility to their clients to find meaning in their own lives (Frankl, 1975, Carkhuff, 1967) and to be good examples. A therapist,

> cannot tell a patient what the meaning is, but he at least can show that there is a meaning in life, that it is available to everyone and, even more, that life retains its meaning under any conditions. It remains meaningful literally up to its last moment, up to one's last breath (Frankl, 1978, p. 41).

Life should not be judged by its length, but by the value of its contents (Frankl, 1965). A person at 30 who dies courageously has attained a higher degree of freedom and is more mature than a person who fears death at the age of 80 and attempts to be shielded from the reality of the finiteness of life (May, 1953). Also, life should not be judged by whether one leaves survivors. Lack of offspring does not make life less meaningful. In fact, desire for more children is a kind of materialism (Frankl, 1965). "Life can never be an end in itself, and its reproduction can never be its meaning; rather, it acquires meaning from other, non-biological frames of reference; intellectual, ethical, aesthetic, and so on" (Frankl, 1965, p. 78).

Additionally, life should not be judged by success. Lack of success does not signify lack of meaning. What gives life meaning are the attempts at success.

How does reorientation occur? According to May (1975) the course of therapy consists of three steps:

a. Establishing the relationship

b. Gaining insight. "Aha" experiences where needed insights are acquired by the patient

c. Action upon new insights

Establishing a humanistic relationship has already been discussed herein. Also discussed were the kinds of questions that can lead to personal insight. Life is a "life-long question and answer period" (Frankl, 1978, p.

110). People must answer these questions for themselves. There are no given answers.

Once insight has been gained, the therapist can help the client to plan creative action. A necessary ingredient for any positive movement is courage. Courage is not the absence of despair, but the capacity to move ahead despite despair (May, 1975).

Other catalysts, in addition to courage, which can help turn insight into action are positive self-esteem (Maslow, 1970; May, 1950), work (May, 1950; Frankl, 1965); belief in leaders (May, 1950), and religious faith (May, 1950; Frankl, 1965, 1967, 1975).

Frankl (1978) gave the example of how he helped a young widow to find meaning after the death of her husband. They had been married for only one year prior to his death. Frankl told her that although her husband was gone, the memories of that one year could never be taken away from her. She had rescued these memories by placing them in the past.

The fact that she had no children also did not diminish the loss because life has its own meaning. Perpetuation of life through the species is not necessary to make someone's life meaningful.

What if the widow were to no longer remember her husband. Then did the loss of memory mean that his life had

no meaning? No, because whether something exists does not depend on someone thinking about it (Frankl, 1978).

The following is an example from Frankl (1975) which illustrates how insight and a positive counseling relationship may turn despair into positive action.

> I am at the age of 54 financially ruined, in jail. At the beginning of this incarceration (8 months ago) everything looked hopeless and irrevocably lost in chaos that I could never hope to understand, much less to solve.
>
> Endless months passed. Then, one day I had a visit by the court psychiatrist to whom I took an immense liking, right from the start, as he introduced himself with a very pleasant smile and a handshake, like I would be still "somebody", or at least a human being. Something deep and unexplainable happened to me from there on. I found myself reliving my life. That night, in the stillness of my cell, I experienced a most unusual religious feeling which I never had before; I was able to pray, and with utmost sincerely, I accepted a Higher Will to which I have surrendered the pain and the sorrow as meaningful and ultimate, not needing explanation. From here on I have undergone a tremendous recovery.
>
> This happened in Baltimore County Prison in April of this year. Today, I am at complete peace with myself and the world. I have found the true meaning of my life, and time can only delay its fulfillment but not deter it. At fifty-four, I have decided to reconstruct my life and to finish my schooling. I am sure I can accomplish my goal. I have also found a new great source of unexpected vivality--I am able now to laugh over my own miseries, instead of wallowing in the pain of irrevocable failure, and somehow there are hardly any great tragedies left. . . (Frankl, 1975, pp. 11-11).

Techniques of the Humanistic Grief Counselor

In general, humanists use any techniques which encourage creativity, spontaneity, courage, and unity of the whole person (Severin, 1967). Neither Maslow, May, Rogers, nor Frankl gives any techniques especially designed for grief counseling.

Frankl (1967) does, however, devote much attention to the importance of religion in logotherapy as a means of finding order and meaning in life and death. Logotherapy is a secular psychotherapy, but if the patients are religious their relationships with God can be used to find meaning. For example, perhaps bereaved people could find comfort in the idea that God has presented them with a personal challenge. Or perhaps the thought that God will not abandon them during their suffering would be a comfort.

In grief counseling, humanists stress the importance of the counselor as a role model (Buehler, 1967; Frankl, 1978). A role model is a person who provides a living example of how to behave to others. As previously mentioned, counselors who really believe that their own lives have meaning and who attack their own problems creatively can show clients how to behave more positively (Carkhuff, 1967). Counselors who are afraid of their own deaths or the deaths of their spouses, are not going to facilitate positive change in the client (Buehler, 1967; Jourand, 1964; Carkhuff, 1967, 1976). To paraphrase Albert Einstein, the counselor who regards life as meaningless is not merely unhappy, but hardly fit to counsel someone else (Frankl, 1978).

Paradoxical intention (Frankl, 1971, 1978), a technique of logotherapy, is not effective with realistic fears such as fear of death (Frankl, 1971). When using

paradoxical intention, the therapist suggests that the client behave in a way opposite from the desired behavior. This is a kind of reverse psychology. This technique is reserved for neurotic fears such as agoraphobia. The grieving spouse experiences many realistic fears which would not be helped by paradoxical intention, but which could be cured by intellectual understanding (Frankl, 1971), a process which has been discussed at length in prior sections of this chapter.

In short, philosophic understanding is the main tool which the therapist can use to help the bereaved client. Some humanists encourage the client to find a meaning in and comfort from God or some general overmeaning. Humanists in general recognize the importance of the counselor as a role model.

Criticism of Humanistic Grief Counseling

Most of the general criticism of humanism centers on its "frequent vagueness" (Child, 1973, p. 19). Often the statements are not easily verifiable by scientific experimentation (Child, 1973). The following are examples of statements not easily verified by scientific experimentation.

"Suffering ceases to be suffering in some way at the moment it finds a meaning, such as the meaning of a sacrifice" (Frankl, 1971, p. 179). "People who claim to be absolutely convinced that their stand is the only right one

are dangerous" (May, 1975, p. 13). "I have likened the peak-experience in a metaphor to a visit to a personally defined heaven from which the person then returns to earth" (Maslow, 1981, p. 66).

Even attempts at scientific validation such as Maslow's (1970) work on peak experiences is informal and lacking in statistical analysis (Child, 1973).

Humanistic writings are full of basic and brilliant insights into human personality, but the authors fail to show how these thoughts fit together. "Nobody has yet written the Principles of Psychology of the new movement" (Wilson, 1972, p. 242). According to Wilson (1972), these pieces do fit together, but it is not readily apparent how they are related.

Another shortcoming found in Frankl's work is his emphasis on the importance of God (Wilson, 1972). His sentimentality sounds like simple religious optimism (Child, 1973). Also, some charge logotherapy centers too much on dying and suffering.

Frankl (1967) answers his critics by saying that it is true that his psychology does center on dying and suffering, but not in a pessimistic way. His is an optimistic view that these things do have meaning. The tragic triad--pain, guilt, and death--are inescapable and must be discussed openly.

In general, little criticism specific to humanistic grief counseling exists other than remarks about Frankl's alleged preoccupation with death and suffering.

Summary of Humanistic Theory

Humanism, a philosophical orientation which stresses the importance of human beings, was adapted into a framework for counseling by Abraham Maslow. Maslow is credited with developing a "third force" in psychology (Goble, 1971; Maslow, 1974). The first and second forces were psychoanalytic and behavioristic theory.

Viktor Frankl, having endured extreme suffering in concentration camps, added to the literature of humanistic psychology by speculation on the meaning of life and death and by developing his counseling philosophy, logotherapy (Frankl, 1971, 1978).

While bed-ridden for a year and a half, Rollo May speculated on the importance of accepting responsibility for one's own life and on the vital part self-discipline plays in daily living (May, 1953). May concluded that even in the face of tragedy, people have the freedom to choose how they will respond (May, 1969, 1975). Rogers (1951) also developed a humanistic approach to counseling, client-oriented therapy. He concluded that each person has the inner strength to respond in a positive way to any situation, regardless of how tragic it may be.

Maslow, Frankl, May, and Rogers did not directly address how to treat the bereaved spouse. This is because humanists view the problems of the grieving person to be no different from the problems of any other client. All people must face their problems with courage, not attempting to circumvent them. They must strive to find meaning in life and to become emotionally stronger. They must somehow turn tragedy into triumph.

Humanists do not discuss stages of grief, but they do mention ways in which abnormal grief may be distinguished from normal grieving. Abnormal grief generally results from attempts to avoid pain.

The goals of the humanistic grief counselor center around movement toward self-actualization for the client. Additionally, three other goals may be discerned: (1) to help clients learn to accept suffering, (2) to help clients find meaning in their suffering, and (3) to help clients to get outside of themselves.

The process of counseling the bereaved occurs, as does other types of counseling, in three stages: establishing the relationship, gaining insight, and acting upon the new insight. The synergistic relationship (Maslow, 1962) with the counselor enables the client to find hope, courage, and intellectual understanding.

Although humanistic counseling theory may be criticized as being vague, overly optimistic (Child, 1973), and

incomplete, humanists do ponder important questions concerning the meaning of life and death. They dwell on the responsibility and innate capacity of all people to meet crisis situations and to grow from them. In the final analysis, it could be argued that all humanistic counseling is grief counseling.

CHAPTER IV

BEHAVIORISTIC THEORY

Historical Perspective and Review of the Literature

Long before behaviorism emerged as theory, isolated behavior therapy techniques were used. In fact, behavior therapy techniques have been recorded for hundreds of years (Kazdin, 1978; Turner, Calhourn, & Adams, 1981). For example, Pliny the Elder (23-79 A.D.) used aversive conditioning to treat alcoholics (Franks, 1969); the son of a Chinese emperor used operant conditioning on the royal cavalry in order to assassinate his father; and in the 1800's a captain in the Royal Navy, Alexander Maconochie, set up a token economy to control behavior in a British prison colony in the South Pacific (Rimm & Masters, 1979). However, the use of these techniques was limited to isolated instances which were later organized into a science by such men as Pavlov (1849-1936), Watson (1878-1958), and Skinner (1904-) (Ehrenwald, 1976; Franks & Wilson, 1979).

Around 1900, classical conditioning, a procedure in which two stimuli are presented to an organism independently of its behavior, was begun by the Russian scientists Sechnov, Bechterov, and Pavlov (Kazdin, 1978). Pavlov (1929), who experimented with dogs and their conditioned

reflexes, is the most well known behaviorist of the group. In addition to his animal studies, Pavlov also investigated the relationship between learning and human psychopathology (Turner et al, 1981).

Reacting against the psychoanalytic focus of psychology in the early 1900's, J.B. Watson adapted the Russian classical conditioning ideas, publishing his famous study of Little Albert whom he sensitized to fear a white rabbit (Watson & Rayner, 1920). Yet today, the actual circumstances of the experiment are clouded by a plethora of fabricated versions of the conditioning (Harris, 1979). Bellack and Herson (1977) and Kanfer and Phillips (1970) outline the classical conditioning paradigm as do many other introductory psychology textbooks. This dissertation will not deal with the particulars of that paradigm.

Other psychologists important in turning psychology away from the dominant introspective mode of therapy, psychoanalysis, were B. F. Skinner (1933) and E. G. Thorndike. They developed operant conditioning which is based on the idea that "behavior is a function of its consequences" (Turner et al., 1981, p. 4). A main difference between classical and operant conditioning is that classical conditioning stresses the stimulus while the emphasis in operant conditioning is on the response.

Despite the many diverse approaches of behavior therapists, general characteristics of modern behavior

therapy treatment can be discerned (Kazdin, 1978; Kazdin & Hersen, 1981). Kazdin (1978) lists these characteristics as follows: (1) focus on current rather than historical determinants of behavior, (2) focus on observable behavioral change as a means of evaluating treatment, (3) specification of treatment in objective terms so that it can be replicated, (4) therapeutic techniques are based on research in psychology, and (5) specific measurements are taken during treatment and after to measure improvement in objective terms.

In 1981, Kazdin revised his list of the characteristics of behavior therapies and omitted the requirement that all therapeutic techniques must be based on research in psychology. Concern has developed among behaviorists that this lack of a strong research base will make behavior therapy less of a science and more of a collection of techniques (Franks & Wilson, 1979; Turner et al, 1981). Behaviorists have long held that their insistence on a strong research base for their theories is what sets them apart from and above the humanists and the psychoanalysts (Franks & Wilson, 1979). "An experimental analysis shifts the determination of behavior from autonomous man to the environment--an environment responsible for both the evolution of the species and for the repertoire acquired by each member" (Skinner, 1971, p. 205).

Behaviorists speculate that animal behavior, including human behavior, occurs in response to the environment. Almost all living things act to free themselves from harmful situations (Skinner, 1971). Skinner concludes that those who from the time of the Greeks have speculated on consciousness as a form of self-knowledge have been wasting their time (Skinner, 1971). Behavior is tied to environmental dictates and hereditary endowment (Skinner, 1974). Humanists and those psychoanalytically orientated do not agree with behaviorists on this issue.

Traditional humanistic and psychoanalytic theories describe humans as being autonomous. This means humans have the freedom to behave as they choose. People can be held responsible for their actions and can be punished for unjust behavior. In the behaviorist view, responsibility for behavior is shifted to the environment.

> Almost all our major problems involve human behavior, and they cannot be solved by physical and biological technology alone. What is needed is a technology of behavior, but we have been slow to develop the science from which such a technology might be drawn (Skinner, 1971, p. 22).

For purposes of this dissertation, three writers have been chosen to represent the behavioristic view of grief counseling. B. F. Skinner is first discussed because he developed operant conditioning upon which others have based their ideas for grief counseling. Skinner also presented a model of social engineering which he claimed would prevent the need for grief counseling (Skinner, 1948).

Prior to 1976, no behavior therapy programs especially designed for the bereaved client existed, although much attention had been given to depression and to other isolated symptoms of the grieving client (Franks & Wilson, 1976). Aaron Beck has been included in this dissertation to represent the behavioristic approach to counseling the depressed client.

In 1976, R. W. Ramsay from the Netherlands first applied behavioral techniques and individual case study strategies to the grieving client. He is included as the third behavioristic theorist.

Each of these three men and their writing will now be presented.

1. B. F. Skinner (1904-)

B. F. Skinner has for years been one of the most controversial living people in the field of psychology. He is, "A rigorous scientist who has applied his carefully wrought brand of 'radical behaviorism' to broad and pressing social problems" (Moritz, 1979, p. 361). However, some people dismiss him as being a "rat psychologist" and they fail to see that his interests are broad and include linguistics, psychotherapy, social issues, and education.

Skinner was born in 1904 in a small town in Pennsylvania. He had only one sibling, Edward, who was nicknamed Ebbe. Ebbe and B. F. were very close during their childhood years.

Ebbe died unexpectedly of a massive cerebral hemorrhage during B. F.'s freshman year at college. B. F. had been talking to his brother, who felt fine, fifteen minutes before his death. Suddenly Ebbe complained of a severe headache. A friend ran for the doctor, but by the time he returned, Ebbe was dead. B. F. reported the symptoms of his brother's death with accuracy and an objectivity which the doctors commented on as helpful. He also objectively watched his parents react to the tragedy (Skinner, 1976).

Skinner did not describe sorrow as his main problem when his brother died, but rather being forced into the "family boy" role in the family which Ebbe had previously filled (Skinner, 1976). Traditionally, in the Skinner family, Ebbe had spent more time with his parents than B. F., who had enjoyed a good deal of freedom. When Edward died, a void was left in their parents' lives and they asked B. F. to spend more time with them. Of course, by this time, B. F. was very busy with his own experiments and studies. He was unable and unwilling to compensate to his parents for Ebbe's death.

A few years later, Skinner experienced the death of his closest friend, Raphael Miller, who died in a boating accident. When the phone rang with the news B. F. was playing Scriabin's Prelude in G-flat Major in the piano, "and I have never heard it or played it since then without

reliving that moment" (Skinner, 1979, p. 39). Skinner dedicated his first book to Raphael Miller.

Skinner is in real life quite different from the mechanical person that some people expect. "At 79, he is not, and may never have been, an unemotional robot. He can be warm, kindly, and sentimental--perhaps more so now that he no longer has to grumble, 'Behave, damn you!' at his pigeons" (Langone, 1983, p. 38).

One proof of Skinner's emotionality is the "N" burned into his left forearm. The "N" is for a girl named Nedda who rejected Skinner. This woman caused him "almost physical pain" and in despair he bent a wire in the shape of an "N", heated it in a bunsen burner, and branded his arm.

> Skinner admits that the breakup hit him very hard--but beyond that he tells the story matter-of-factly, without conveying emotion or offering any interpretation. He says flatly, 'I do not think feelings are important. Freud is probably responsible for the current extent to which they are taken seriously (Langone, 1973, p. 38).

While in college, Skinner was encouraged by Robert Frost to become a novelist, but after a year he gave up his writing career concluding that he had nothing to say. In 1928, Skinner decided to study psychology and he received his Masters Degree in Psychology from Harvard in 1930 and his Ph.D. from Harvard one year later (Mortiz, 1979). Upon completion of his Ph.D., he remained at Harvard where he spent five years in basic research. Two years were under the National Research Council fellowship and three years

were as a Junior Fellow in the Harvard Society of Fellows (Evans, 1968).

Skinner was always mechanically skilled and while at Harvard he conceived and produced the device which has become known as the "Skinnerian Box". This box is a controlled environment for observing and recording behavior (Skinner, 1938). It was intended to replace the mazes which rats were expected to run. The box is more simple than the maze as it presents a simple task such as pressing a lever which is rewarded by a piece of food.

Skinner's first book, The Behavior of Organisms (1938), reported some of his early systematic observations. Skinner's experiments centered on "operant" behavior which is the spontaneous behavior of an organism in response to its environment. Operant conditioning examines the consequences of many voluntary and unprompted behaviors. The consequences are, "evaluated by the vigor of the action after it has been associated with reinforcement. Vigor of action (strength of learning) is characterized by the rate of elicitation of the behavior being studied, and the reinforcement which lead to its increase" (Eysenck et al., 1972, p. 202). Similarly, a contingent event may lead to a decrease in response rate. These events are called punishing or non-reinforcing. As previously mentioned, operant conditioning differs from classical conditioning which

concentrates on the reactions which occur in the central nervous system (Eysenck et al, 1972; Moritz, 1979).

Skinner came to the attention of the public when he invented his baby-tending machine for his second daughter, Deborah (Skinner, 1947). It was intended to be a special kind of baby crib which allowed the child to live in a comfortable environment and not wear clothes or diapers (Skinner, 1979). Unfortunately the baby-tending machine was confused by the general public with Skinner's box which had been developed for rat experiments. Skinner was criticized for reducing a baby to the level of a rat (Moritz, 1979). This, of course, had never been Skinner's intention (Zito, 1946). When Deborah outgrew the baby-tending machine, Skinner moved it to his laboratory where he converted it into an easily cleanable rat house (Skinner, 1979).

During World War II Skinner turned his attention from rats to pigeons. He received a government grant of $25,000 to develop Project Pigeon. Skinner believed that birds could be trained to guide missiles to destroy enemy bombs and torpedoes. Although the plans looked workable, they were never used. These experiments are described in Schedules of Reinforcement (1957).

In addition to animal behavior, Skinner also studies human behavior. In fact, one of Skinner's major works, Walden Two (1948), is a controversial novel which describes a society where the behaviors needed to keep it going are

automatically reinforced. In this novel, a college professor, two service men, and their fiancees visit a modern American colony for a week. During this time the principles of the colony are studied thoroughly. The main goal of Walden Two is to point out a possible solution to the problems of American society.

> The choice is clear, either we do nothing and allow a miserable and catastrophic future to overtake us, or we use our knowledge about human behavior to create a social environment in which we shall live productive and creative lives and do so without jeopardizing the chances that those who follow us will be able to do the same (Skinner, 1976, p. xvi).

In 1971, he published his controversial work, Beyond Freedom and Dignity. In this book he presents the same ideas as in Walden II, but instead of writing in fiction as in Walden II, Beyond Freedom and Dignity is non-fiction and lacks the humor of the novel. According to Skinner (1971), all of humankind's major problems involve human behavior and they can only be corrected by societal change. People need to develop a technology of behavior which selects and reinforces proper and constructive behavior.

In 1974 he published About Behaviorism in which he argues that man has no autonomous "inner being". Personal freedom does not exist because everyone is subject to a complex system of rewards and punishments which are an integral part of the environment. As in 1971, Skinner advocates that social engineering should be undertaken so that people behave in a manner conducive to the growth of

the common good. In this book, Skinner (1974) maintains that he is not advocating that old views about psychology be discarded, but merely that they be redefined.

Skinner has also written a three book autobiography (1976, 1979, in press). The autobiography attempts to accurately report how Skinner developed his often controversial ideas (Skinner, 1983).

Today, at age 79, Skinner weighs 132 pounds at five feet nine inches (Langone, 1983). Because of cancer of the salivary glands in 1980, he lost his ability to taste for a while. During this time, Skinner lost weight, but rarely stopped work. His daily routine begins at 4:40 a.m. After breakfast, he works at home in his study from 5:00 to 7:00 a.m. Then he walks the 2-1/2 miles to Harvard where he works until exactly noon when he walks home. In the afternoon he relaxes by reading, but he does not do any heavy thinking. Skinner thinks that by allowing himself relaxation time doing such things as watching television, he is able to work better in the mornings (Skinner, 1983).

Skinner's ideas about the meaning of life and death are consistent with his behavioristic principles. He believes that humans live for the purpose of producing a product which survives after their death. To explain this idea, he compares humans to radishes.

> A radish is the way in which radish genes make more radish genes. If I am right about human behavior, an individual is only the way in which a species of a culture product more of species and a culture. It

> remains a matter of selection even when species and cultures are changed by explicit design (Skinner, 1983, p. 33).

Skinner views himself as an organism to be studied, "My behavior at any given moment has been nothing more than the product of my genetic endowment, my personal history, and the current setting" (Skinner, 1983, p. 25).

Skinner does not fear death because his books are his immortality. He will live on in them. "If some Mephistopheles offered me a wholly new life on condition that all records and effect of my present life be destroyed, I should refuse" (Skinner, 1983, p. 32).

In summary, B. F. Skinner has dealt as unemotionally as possible with life and death in his own experience. He sees the product of a person's life as being more important than the person who produced it.

2. Aaron T. Beck (1921-)

Beck was born on July 18, 1921, in Providence, Rhode Island. He married Phyllis Whitman, an attorney, in 1950 and had four children, two boys and two girls. He received a B.A. degree magna cum laude from Brown University in 1942 and an M.D. degree from Yale University in 1946. He is currently a professor of psychiatry at the University of Pennsylvania and is affiliated with the Hospital of the University of Pennsylvania. Beck is the Chief of the Department of Psychiatry of Philadelphia General Hospital (Nasso, 1977; Beck, 1977).

Beck is a behaviorist (Franks & Wilson, 1977, 1978) who has written extensively on depression and suicide. Beck's best known work, Diagnosis and Management of Depression (1973), is landmark research which describes depression and behavioral treatment of this illness. He has developed a scale to measure depression (1979) and a scale for measuring masochistic dreams which are present in many depressed people (Beck, 1979).

Beck has authored and co-authored numerous articles on suicide (i.e., 1974, 1976). He has been especially concerned with determining the degree to which attempted suicides are similar to completed suicides. Beck is trying to develop a means of predicting which people intend to successfully complete suicide and which intend to fail at taking their own lives. He has already found that people who do not successfully complete their suicide attempts always intend to contact another person, their only question is whether to call someone before or after they have harmed themselves. For example, individuals might take pills to kill themselves. If they did not intend to really die, they would contemplate whether to call someone before taking the pills or after taking the pills. On the other hand, people who fully intend to kill themselves ponder whether or not to call someone rather than when to attempt communication. This is a subtle difference in thinking, but an important distinction in measuring intent to commit suicide (Beck &

Lester, 1976). Over the last 10 years, Beck has published more than 80 articles in professional journals on depression. He is currently writing on psychotherapy (Press, 1973; Nasso, 1977).

As previously mentioned, Beck is well known for his treatment of depression with cognitive therapy, a behavioristic technique (Beck, 1973, 1977, 1979). Cognitive therapy for depression is based on the idea that depression arises when a person misunderstands the environment and perceives things in an inaccurate and negative way. Cognitions and thoughts misrepresent reality and depression ensues (Beck, 1979). Cognitive therapy treatment for depression will be discussed more fully in the "Process" section of this chapter.

According to Beck, "The relationship of cognition to affect in normal subjects is similar to that observed in psychopathological states" (Beck, 1974, p. 127). Normal subjects respond to losses with an appropriate affect, sadness. In the psychopathological condition, depression, the stimulus situation comes more from an internal perception of the environment than from an objective evaluation of what is actually happening. "The affective response, furthermore, is likely to be excessive or inappropriate because of the idiosyncratic conceptualization of the event" (Beck, 1974, p. 127).

When people experience a loss such as the death of a spouse, sadness results in varying degrees depending upon the amount to which the survivors feel that their domains have been reduced. As long as bereaved people are responding to real environmental loses in appropriate ways, they are experiencing the normal reaction of sadness. If, however, distortions and misinterpretations of these losses begin, then the normal affect of sadness gives way to an abnormal pathological disorder, depression. "Depressed patients . . . tend to interpret their experiences in terms of their being deficient or deprived. Hence, a high proportion of their thought content includes ideas of being inferior, destitute, deserted, unloved, or physically deteriorated" (Beck, 1974, p. 135). Depressed people usually blame themselves for their losses. They feel that their problems are due to their own deficits.

So, when Beck speaks of depression, he is referring to a psychopathological disorder which results from a loss. Loss in normal people produces sadness, but when people react to their losses by making cognitive errors of misinterpretation such as blaming themselves for things beyond their control, then depression sets in. Depression can be cured by cognitive therapy (Beck, 1977) which corrects inaccurate thinking and introduces appropriate responses to environmental stimuli.

3. R. W. Ramsay (-)

Little biographical information is available for Ramsay because he lives in the Netherlands and has been publishing in the United States for only a few years. Ramsay is a professor in the Department of Psychology at the University of Amsterdam. For several years, he devoted himself to the behavioristic treatment of grieving people (Franks & Wilson, 1979). He is especially concerned with the grieving spouse (Ramsay, 1977b, 1979). In 1979, Ramsay gave up treating grieving people because this work was too psychologically and physically draining for him. He is currently on leave due to illness from the University of Amsterdam.

Ramsay has taken his description of grief from Averill (1968), Bowlby (1960), Siggins (1967), Parkes (1972) and from his own personal experience treating bereaved clients (Ramsay, 1977b). Ramsay has published several articles in Dutch, four of which have been translated into English (Ramsay 1976, 1977a, 1977b, 1979). In 1976, he published a case study of a woman who had suffered multiple losses within a short period of time. This case study was the first article by Ramsay which was published in England. Each of the three other articles by Ramsay built on the principles presented in this first case study. Ramsay's work is significant for the following reasons:

1. He is the first to develop a systematic behavioristic approach (implosion) for grieving people (Ramsay, 1977b, 1979).
2. Ramsay is able to use psychoanalytic, and humanistic ideas to augment his behavioristic therapy.
3. Ramsay (1977a) presents the idea that grief symptoms are "components" of grief and do not occur in "stages".

According to Ramsay (1979), behaviorists can learn from other schools of psychology when studying grief. The psychoanalytic literature describes the grief process and the emotions involved. The Rogerian school teaches listening skills and Gestalt therapy offers useful techniques; however, the main treatment for grieving is that of behavior therapy (i.e., flooding, repeated confrontation, prolonged exposure and response prevention when the client attempts to avoid or to escape grief work) (Ramsay, 1979). Ramsay defines "grief work" as Parkes and Bowlby do. That is, grief work is the process whereby the bereaved person lets go of the deceased loved one and is able to adjust to life without him or her.

Ramsay suggests that two other behaviorists have contributed to his understanding of the grieving process. Seitz (1971) sees depression as a result of inadequate or insufficient reinforcers. "A depressed person can be viewed

as on an extinction trial: some significant reinforcer has been withdrawn, weakening the person's behavioral repertoire" (Seitz, 1971, p. 131). Seligman's (1975) concept of learned helplessness also influenced Ramsay. Anxiety is the first reaction to stress, but if there is no way to change the situation, depression sets in replacing the anxiety.

In short, Ramsay has developed a behavioristic approach to help grieving clients. Ramsay uses his implosive therapy on a few selected clients who are able to endure this difficult treatment. Psychoanalytic theory and humanistic techniques are an important part of this therapy. The primary value of Ramsay's work is his compassionate understanding of grieving people and his ability to develop creative ways to alleviate abnormal manifestations of grief.

Behavioristic Description of the Mourning Process

This section which describes the mourning process is organized around the following five questions:

1. What are the characteristics of the normally grieving spouse?
2. Do these characteristics appear in stages? What are these stages?
3. How long does the grieving process last?
4. What is the difference between normal and abnormal grief?
5. Is grief an illness?

The answers to these questions will be taken from the works of B. F. Skinner, A. T. Beck, and R. W. Ramsay.

1. What are the characteristics of the normally grieving spouse?

In Skinner's utopian society, Walden Two (1948), the mourning process is part of life because deaths do occur. In Walden Two, a person whose spouse dies will feel the loss, but rapid adjustment to a new life without the deceased will occur because the community provides a supportive network. Although a loved one may be gone, the surviving people are independent enough to not be devastated by the loss.

Some symptoms of depression can be triggered by the death of a loved one (Beck, 1977). For example, Beck (1977) reports a woman who became depressed when her husband and all her children were killed in an automobile accident. This woman experienced the following themes in her thought patterns. These themes are common to depressed people in general.

a. low self-esteem. People who have low self-regard tend to magnify their failures and to ignore their favorable characteristics. What they think of themselves is often not in line with reality. For example, a beauty queen may think she is ugly or an anorexic may thing that she is fat. "A common feature of many of the

self-evaluations was the unfavorable comparison with other people, particularly those in his own social or occupational group" (Beck, 1967, p. 231).

b. self-blame. Depressed people may blame themselves for everything that goes wrong including things that could not possibly be their fault. For example, a man took his family on a picnic and then blamed himself when rain forced them to go home early.

c. feeling of overwhelming responsibilities. Depressed people consistently magnify their responsibilities and problems. The smallest task becomes overwhelming. The world has given them too much to do, so they become incapable of doing anything.

d. desire to escape. Depressed people often retreat to bed as a means of escape. Sometimes they hide under the covers for days. Part of the reason they want to escape is that they are constantly commanding themselves to do mutually exclusive things. For example, within a one hour period a woman who was trying to make a bed might think that she should get a full time job, paint the house, do more volunteer work, go back to school, and have more children.

> There is no way that she can meet all these goals and because she fails, her self-esteem falls even lower (Beck, 1967, 1977).

The characteristics of depression which occur in varying degrees of severity are:

1. A change in mood: sadness, loneliness, apathy.
2. Negative self-concept including self-blame and self-reproachment.
3. Regressive and self-punishing wishes to escape, to hide, or to die.
4. Physical changes: anorexia, insomnia, loss of libido.
5. Change in activity level, either more activity or less activity (Beck, 1977).

According to Ramsay's earlier writing (1977a), bereavement is a type of depression. The accompanying feelings are, "hopelessness, helplessness, failure, sadness, unworthiness, guilt, anxiety, loneliness, and sometimes feelings of persecution" (Ramsay, 1977b, p. 131). In a case study, Ramsay (1976) describes the symptoms of the grieving client as agitation, sleeplessness, inability to complete everyday tasks, and aggressive impulses.

In Ramsay's more recent article (1979), he describes bereavement as a process of which depression is one component or phase. He seems to have changed his view that bereavement is a type of depression (1977b) in favor of a

broader view that depression is one phase of bereavement. Ramsay (1977a, 1977b, 1979) acknowledges the contributions that psychoanalysts have made to the field of grief counseling. "From the psychoanalytic literature we have descriptions of grief processes and the emotions involved, so that the therapist knows in advance what to expect in the way of the nature and content of emotional responses" (Ramsay, 1979, p. 217). For an explanation of these characteristics of grieving see Chapter II of this dissertation.

The question can then be asked as to whether Beck's description of depression is compatible with the psychoanalytic picture of bereavement which is accepted by Ramsay. Since psychoanalytic theorists (Lindemann, 1944; Bowlby, 1960; Parkes, 1972) recognize some degree of depression as a normal part of bereavement, it seems that Beck's work serves to expand their understanding of the normal depression which Beck calls sadness, often found in bereavement and the clinical depression sometimes found in abnormal grief.

2. Do these characteristics appear in stages? What are these stages?

Of all the behaviorists, only Ramsay writes about whether or not the characteristics of grief appear in stages. According to Ramsay (1977a, 1977b, 1979), grieving does not occur in stages because the order in which symptoms occur is unpredictable. So much "regression" occurs during bereavement that the word "components of grief" seems a more

accurate term than "stages of grief". Ramsay (1977b, 1979) has taken the main features of grieving from Parkes and Bowlby (see Chapter II). He promotes his model despite recent criticism of the "stage theories" of grieving (Bergen, 1977) because he thinks that the therapist needs to have an overall view of what can be expected from the grieving client (Ramsay, 1979). For example, during the first weeks of bereavement there is always a period of shock and desolation characterized by outbursts of crying. If this did not occur the therapist would know that the grief was being held back. If crying is not begun by the time of the funeral, this is a bad sign (Ramsay, 1979).

> If this component is not in evidence by the time of the funeral, it is a sign of a poor prognosis, yet mourners are often praised by the social network for being brave and not breaking down. (The stiff upper lip, the "Jackie Kennedy Syndrome", is not universal. In certain societies, paid mourners, brought in to cry and howl, will continue wailing the deceased's name until the griever joins in) (Ramsay, 1979, p. 222).

Ramsay's scheme of grief is shown on Table 1. Shock is the first component of grieving which can be momentary or can last for weeks. The "duration and intensity of this phase corresponds with the amount of difficulty with which the rest of the bereavement process will be worked through" (Ramsay, p. 221).

Disorganization is a component of grieving shown when people are unable to do anything or when they become hyperactive, meticulously taking care of all the tasks

Table 1

Phases or Components of Grieving

Phases or components of grieving.

SHOCK

DISORGANIZATION

DENIAL

- Searching Behavior
- Emotional components
  - Desolate Pining
  - Despair
  - Guilt
  - Anxiety
  - Jealousy
  - Shame
  - Protest, aggression

RESOLUTION AND ACCEPTANCE

REINTEGRATION

(adapted from Ramsay, 1979, p. 221)

presented by the death of their loved one. The therapist is seldom needed at this stage (Ramsay, 1979) but may be used with a high risk population (Raphael, 1975) such as people who have previously been hospitalized for emotional problems.

Ramsay (1977b, 1979) takes many of the features of grieving in his model (see Table 1) from psychoanalytic literature. However, he uses the term "desolate pining" instead of the term "depression" to distinguish it from "clinical depressive illness" in which the patient has general feelings of worthlessness. These feelings of worthlessness rarely occur in normal grief (Ramsay, 1979).

Denial is placed outside the brackets in this grief component model (Table 1) because it appears throughout the process. Searching is one kind of denial as are the emotional components found within the brackets. This denial is a defense mechanism which is useful in that it helps people to accept grief a little at a time. On the other hand, denial is also harmful because it prolongs the process and thus increases the length of grieving time.

Many people cannot feel or express guilt, anger, and the other components of grief. They need emotional training with modeling and encouragement to express their repressed feelings.

3. How long does the grieving process last?

Neither Skinner, nor Beck speculates on how long the grieving process normally lasts. However, since Ramsay (1977b, 1979) borrows his description of the grieving client from psychoanalytic literature, he concludes that, although the length of time for grieving varies greatly from individual to individual, active grieving past one year or two years is not considered normal (Freud, 1909/1955; Marris, 1958; Glick et al, 1974).

4. What is the difference between normal and abnormal grief?

B. F. Skinner has described in Walden Two (1948) how a society can promote normal bereavement. In times of loss the community provides its mourners with sincere sympathy and support. Because the community offers so much genuine comfort, professional mourners are not needed. In Walden Two, the comfort for mourners lies in their hope for the future not in their belief in happiness in the next world after their deaths. "We like it well enough here on earth. We don't ask to be consoled for a vale of tears by promises of heaven" (Skinner, 1948, p. 166).

According to Skinner, "The psychological problems of group living could be solved with available principles of behavioral engineering" (Skinner, 1948, p. 9). He thinks that negative emotions such as sorrow are not particularly useful and could be eliminated in this way. Behavioral

engineering begins with children at the age of 3 or 4. The children are taught to endure minor discouragements. By being exposed to small frustrations, they are able to cope with problems which may occur later in life. Because they are equipped with sufficient coping mechanisms, as adults these children are happier and less likely to experience unnecessary and unproductive emotions such as guilt, anger, and sadness. The productive and strengthening emotions such as joy and love are useful and are an important part of life, but sorrow and hate, anger, fear and rage are, "wasteful and dangerous" (Skinner, 1948, p. 83).

In Walden Two (1948) several specific examples of how behavioral engineering works with children are given. For example, when hungry children age 3 or 4 are brought in for dinner after hours at play they all stand in front of their food. Then a coin is flipped and the children are given numbers. The toss of the coin determines whether the odd or even numbered children are allowed to begin eating. The other children must stand for five minutes before they are allowed to begin their dinners. In this way, the children learn self-discipline. Self-discipline leads to happiness and emotional maturity.

In Walden II, people are not free of all emotion but,

> the meaner and more annoying--the emotions which breed unhappiness--are almost unknown here, like unhappiness itself. We don't need them any longer in our struggle

> for existence, and it's easier on our circulatory system, and certainly pleasanter, to dispense with them (Skinner, 1948, p. 83).

Emotions, just like behavior, can be controlled with positive reinforcement. Almost any child can be taught by the age of six to be a happy person for the rest of his life. Skinner explains positive reinforcement as follows:

> if it's in our power to create any of the situations which a person likes or to remove any situation he doesn't like, we can control his behavior. When he behaves as we want him to behave, we simply create a situation he likes, or remove one he doesn't like. As a result, the probability that he will behave that way again goes up, which is what we want. Technically it's called "positive reinforcement" (Skinner, 1948, p. 216).

Unfortunately, our society is not the society Skinner describes in Walden II and the emotions of grieving are not as easily dealt with as in such a supportive community as Walden II.

Behaviorists (Beck, 1977; Ramsay, 1976, 1979) consider the difference between normal and abnormal grieving to be one of duration and intensity. On this point the psychoanalytic, the behavioristic, and the humanistic theorists agree. Mourning is pathological if reactions are excessively severe or violent, or unduly long. Mourning which lasts too long may be due to delays in beginning the process, slowing of the process once it has begun, or both (Siggins, 1967; Ramsay, 1976). Ramsay (1976, 1979) states that grief is considered normal unless it is so severe as to need clinical intervention.

Pathological grief arises when people attempt to avoid grief, that is, to avoid the pain (Hodge, 1972; Ramsay, 1976, 1977b, 1979). "A grief reaction will only become pathological if no confrontation takes place and the emotional reactions have no chance to extinguish" (Ramsay, 1976, p. 230).

In this way, abnormal grief develops as phobias develop, that is, there is an avoidance of situations that will trigger the sense of loss. The grieving person will avoid certain songs, certain streets, and "linking objects" in general (Volkan, Cilluffo, & Sarvay, 1976). (Linking objects are discussed in the techniques section of this chapter.) Abnormal grief reactions are like phobic reactions in that they, "are characterized by anxiety in, and avoidance of, an objectively harmless situation" (Ramsay, 1979, p. 227).

Ramsay's (1979) description of how abnormal mourning develops matches Eysenck's (1967) three stage model for the development of phobias. This model is as follows:

1. Single traumatic event or a series of traumas produces unconditioned emotional reaction;
2. Conditioning--previously neutral stimuli becomes connected with unconditioned stimulus. Now the conditioned (CS_s) and unconditioned stimuli (UCS_s) produce a strong emotional behavior; and

3. Lack of extinction produces a third stage. Approaching the CS causes fear and anxiety and retreating reduces this emotional response, thus reinforcing the fear (Eysenck, 1967).

Other research has shown a correlation between the onset of phobias and bereavement. One study of 135 phobics (Roth, 1959) found that 50% of all patients who had agoraphobia developed the illness after the death of a loved one. Somehow these people got "hung up" in the bereavement process (Ramsay, 1979).

Ramsay (1977b, 1979) has taken care to show the developmental link between phobias and abnormal grief because his treatment for abnormal grief is the same as that used by Eysenck (1967) to treat phobias. Tactics used on phobic people have been successful with the bereaved (Ramsay, 1977b).

Ramsay (1979) concludes that lack of adequate reinforcers (Seitz, 1971) in bereavement contributes to the depression often found in abnormal bereavement. Also, learned helplessness contributes to abnormal depression (Seligman, 1967). Since bereaved people are powerless to do anything about death, they conclude that they might as well do nothing. No action takes place, depression sets in and "No 'working through' of bereavement takes place" (Ramsay, 1979, p. 227). "Grief work", as Ramsay uses the term, "is elicited by a rather well-defined stimulus situation,

namely, significant object (or role), and it is resolved when new relations are established" (Averill (1968) in Ramsay, 1979, p. 219).

A person whose general means of coping is to withdraw from pain rather than to face it, is likely to have a difficult time with grieving (Ramsay, 1979).

To summarize Ramsay's theory on how abnormal grief develops,

> a person suffering from pathological grief has lost a major portion of the positive reinforcers in life, has learned that nothing helps to relieve the stress, and so either does nothing in the way of confronting herself with the situations that could lead to an extinction of negative conditioned emotional response, or, like the phobic, actively avoids those situations (Ramsay, 1979, p. 338).

Avoidance merely increases the conditioned fear and anxiety reactions.

There is clearly a link between depression and bereavement, although the connection between the two has as yet been totally uncovered. Ramsay (1977b) describes a pathological grief reaction as one type of depression. Rush and Beck (1978) describe depression as a pathological result of loss. The normal result of loss is sadness.

Beck (1977) has found a relationship between childhood bereavement and clinical depression in later life. A group of 297 inpatients in a psychiatric ward were evaluated to see if they had been orphaned before the age of 16. "One hundred patients who received high-depressed scores on the

depression inventory showed a significantly higher incidence of orphanhood before age 16 (27 per cent) than did the 100 low scorers (12 per cent)" (Beck, 1977, p. 226). These results provide evidence that the death of a parent in childhood may cause depression in later life.

So, clinical depression, whether part of bereavement or not, is never considered normal. Whether depression is abnormal or not is a matter of how severe it is and how long it lasts (Beck, 1977). The clinical depression which frequently occurs in an abnormal grief reaction is the same as any other clinical depression (Beck, 1977; Ramsay, 1979).

5. Is grief an illness?

Normal grief is not considered an illness unless it is so severe as to need treatment (Siggins, 1967; Ramsay, 1979). A pathological grief reaction is an illness and requires psychiatric intervention in order to insure a rapid recovery (Ramsay, 1979). Clinical depression is clearly an illness which requires professional intervention (Beck, 1967, 1977).

According to Skinner (1948), abnormal grief reactions are the result of an ineffectual society which does not offer proper support to its bereaved and does not precondition people to adjust to adversity.

To summarize, the behavioristic description of mourning process has been largely adapted from the psycho-

analytic study of grieving people. Ramsay (1977a, 1979) has modified the "stage" theories of the psychoanalytic theorist to allow for more regression by detailing components of grief. Also, the relationship between bereavement and depression, both mild and severe, has been discussed (Beck 1967, 1977).

Behaviorists consider the difference between normal and abnormal grief to be one of intensity and duration of symptoms. Abnormal grief seems to be similar to phobic reactions (Ramsay, 1979) and is viewed by behaviorists as an illness. Normal bereavement is not considered an illness.

Goals of the Behavioristic Grief Counselor

The behavioristic grief counselor has two main goals:

1. To offer support during the acute phase of depression or bereavement so the client will accept the reality of the loss; and
2. To learn new ways of confronting problems so that further set backs do not occur.

These goals will now be discussed in turn.

1. To offer support during the acute phase of grieving so the client will accept the reality of the loss.

Many people pass through the acute phases of grieving with few problems. Other bereaved people may need a

type of humanistic or phychoanalytic therapy to help them deal with their loss (Ramsay, 1977b, 1979).

> If the loss has been within the previous year, this is a normal reaction and it would probably be better if the professional encouraged the griever to try and work it through on her own, with help from others in the social network. Where there is no adequate social network, a supportive, empathic treatment of a nondirective nature . . . may be indicated (Ramsay, 1979, pp. 228-229).

Ramsay's flooding therapy is appropriate only for those people whose grief reactions have developed in a pattern similar to phobias. In these clients extinction of conditioned fear is unlikely because these clients continually avoid the CS, conditioned stimuli. That is, they avoid facing the reality that the loved ones are really gone forever. For extinction to take place, the reality of the loss must be recognized by the clients (Ramsay, 1976, 1979).

Ramsay's case history (1976) of Mrs. S. is an example of a person in the acute phase of mourning. Mrs. S. had faced multiple losses.

Mrs. S. had been pregnant and her husband who had asthma did not want her to have the child because he feared that the baby would inherit his condition. So, he beat Mrs. S., causing her to miscarry the baby. Then her two pet horses died and her mother died unexpectedly. Within a year, Mrs. S. became pregnant again and again her husband beat her until she delivered a nine month stillborn baby. In the last month of her third pregnancy, her husband again expressed the opinion that she should not have a baby and he

became so upset during the argument that he had an asthma attack and died. Two days later Mrs. S. delivered a normal baby.

Under the insistence of her family doctor, Mrs. S. made an appointment with a psychiatrist who died in a traffic accident on the way to her appointment. Mrs. S. was then admitted on an in-patient basis to a psychiatric hospital where she was treated by Ramsay (1976).

Mrs. S. was unable to admit that her husband had died. She still talked to him and refused to admit that he was gone. Psychoanalytic therapy to help her face the loss would take at least a year and involve a lengthy hospital stay (Ramsay, 1976). She was suicidal and a danger to her child. In order to shorten the length of time required for the therapeutic process and to return Mrs. S. to her daughter, flooding was used (Ramsay, 1976).

If clinical depression is part of the acute phase of bereavement, cognitive therapy (Rush & Beck, 1978) may be used. The goals of cognitive behavior therapy are:

a. To recognize how cognition affects behavior
b. To monitor negative thoughts
c. To think about these distorted cognitions to determine whether or not they are accurate
d. To substitute more reality-orientated interpretations of those conditions which were formerly thought hopeless (Rush & Beck, 1978).

The process of cognitive therapy will be discussed in the next section of this chapter.

2. To learn new ways of confronting problems so that further set-backs do not occur.

When people face their grief rather than running away from it, they learn that they are capable of coping with pain and hardship. Through the therapy process of releasing repressed feelings and emotions, clients learn how to handle similar problems in the future (Ramsay, 1979).

Clinical depression is often a recurrent problem. Any treatment of this illness must incorporate a strengthening of the personality so that the same problems do not arise again. In order to accomplish these goals for therapy, the therapist must expect violent outbursts such as crying fits, angry outbursts, panic reactions, and threats of suicide. The therapist must continue to present stimuli which causes these outbursts until they extinguish themselves. This may take hours and the therapist must be prepared to sit until extinction occurs (Ramsay, 1976).

Therapists also have the problem of facing their own issues concerning death. "The therapist is quite liable to find that his own bereavement experiences hinder him in the therapy, and that he has to face his own fears of breaking the taboo and dealing openly with death" (Ramsay, 1976, p. 235).

In Ramsay's grief therapy, the role of the counselor shifts back and forth from a hard taskmaster to an empathic listener. Only a counselor experienced in many types of therapy is able to accomplish these transitions successfully (Ramsay, 1979). The counselor must constantly evaluate whether or not the clients are on the right track toward facing their grief. In other words, the counselor must be strong enough and experienced enough to handle this type of treatment (Ramsay, 1976, 1977b, 1979). The counselor must also be able to openly discuss death and to accept it as a part of life.

The Process of Behavioristic Grief Counseling

This section describes two behavioristic processes for counseling bereaved people. The first to be discussed is Ramsay's implosion process for treating repressed grief. The second is Beck's cognitive therapy for treating depression. Skinner offers no process for grief counseling because in Skinner's Walden II (1948) grief counseling is never needed.

1. Ramsay's flooding therapy

Most people grieve normally at their own rate and never need counseling or treatment. Within the first year of bereavement, a social network would be the best way to help the mourner (Ramsay, 1977b, 1979). If no social network is available, then supportive, empathic therapy would

be useful (Raphael, 1975), but not the treatment described below. The only exception is when the circumstances are dire, such as a client who has attempted suicide or wishes to kill another (see case history, Ramsay, 1976). In the case history in point, the only choices for Mrs. S. were suicide, murder, long hospitalization, or an intense flooding treatment.

The people who need treatment are those who get stuck in one component of grief such as anger. They have begun the grieving process, but become enmeshed in it and are unable to move forward. The treatment will not make the pain go away, but will help to formalize it facilitating extinction.

When a person totally avoids all stimuli and situations which could facilitate the grief process, but the situation is not a matter of life and death, this therapy is not used. For example, a fifty year old woman went on as she always had after her husband died suddenly; talking to him, setting a place for him at the table and watching his favorite television programs. In such a case of complete denial the therapist would not try to force reality (Ramsay, 1979).

Because this treatment involves a great deal of stress, it can be used with a limited number of clients. The successful candidate should not have a history of psychiatric problems, should have a strong supportive

network, and should have possibilities open for a better life after the treatment. For example, a possible candidate might be, "a 48-year-old woman, married to a doctor, with two daughters, who lost her 10-year-old son in an unsuccessful heart operation; after 3 years she was still severely depressed" (Ramsay, 1979, p. 220).

Another example of a good candidate was a Jewish woman, 54 years old, intelligent, introspective, married, with three children, whose parents were liquidated in Nazi concentration camps during the war. After more than 30 years she asked for help to finally bury her parents in her own mind (Ramsay, 1979).

The therapist has to carefully judge who would benefit from this therapy. Any person who was unable to deal with stress would be eliminated. People with poor physical health would be considered a poor risk.

Of course, when suicide is threatened, the client must be hospitalized while undergoing this treatment.

The MMPI is not necessarily a good instrument to use to determine who is psychologically strong enough to withstand this treatment. It is difficult to tell from MMPI scores whether a grieving person is psychotic or not because often bereavement will cause the psychotic scales to be abnormally elevated (Ramsay, 1979). These scales frequently return to normal after the abnormal grief has been treated. Ramsay's treatment has been used successfully when the MMPI

scores have been "frightfully high" prior to treatment (Ramsay, 1979, p. 229).

Personal appearances are often deceiving and not a good indication of whether or not a person needs this treatment. When Mrs. S. (Ramsay, 1976) entered the hospital she was smiling and emotionally inhibited. Her MMPI t scores showed neuroticism, 98th percentile; psychosomatic tendencies, 96th percentile; extroversion, 9th percentile; and lie scale in the 32nd percentile. One year later, after treatment, the neurotic score was lower, but still her test scores were far from the normal profile (Ramsay, 1976).

The treatment itself is the same as used with phobics. It is flooding and prolonged exposure to the conditioned stimuli that arouse the conditioned emotional responses. This treatment has been effectively used with phobics (Eysenck, 1967) and has been used effectively with a limited number of grieving clients (Ramsay, 1976, 1977a, 1977b, 1979).

> My subjective ratings of improvement, for what they are worth, are 9 highly improved, 9 moderately improved, 4 slightly improved, 1 unchanged, and none worse. The clients' ratings are somewhat higher than mine. These ratings are only to be taken as indicators of a trend (Ramsay, 1979, p. 245).

Systematic desensitization which has also been used with phobics cannot be transferred for use with grieving clients because the emotional reactions are usually too strong (Ramsay, 1979). A hierarchical program can be developed, but all levels of the program produce intense

reactions. Also, phobics can usually list the situations which frighten them more readily than the grieving client can. So, flooding is the prescribed treatment.

The clients must be carefully prepared for the treatment and must understand the program they are committing themselves to follow. The therapy must be laid out for clients and they must understand that it is harsh and painful. In fact, after the explanation of the therapy, two clients were so fearful of the treatment that they cured themselves (Ramsay, 1979).

A list of rules for the clients follows:

1. You may not break off the treatment halfway. There will be a tendency at the low points to want to stop, but that is exactly when you have to go on. I then set a time limit of X weeks or months, X being a rough estimate of how long the therapy will take, multiplied by two. If we are not finished within that time, we can renegotiate.

2. You may not commit suicide during the treatment; afterward you may do what you like, but no suicide during therapy. Most clients laugh at this, but it has helped on a number of occasions that the client is bound by a promise for a limited time.

3. If there is a real danger of suicide and breaking off the treatment you must be prepared for a short period of hospitalization.

4. You may become angry with me during the therapy, but you may not hit me or break up the furniture.

5. Finally, you and I will be working together as a team on a problem--your grief. If I go too fast or push too hard, say so and we can come to a compromise; if my probing becomes too

> painful, tell me to ease up. You have as much say in the matter as I have (Ramsay, 1979, p. 230).

The client should be off all medication such as tranquilizers and sleeping pills. "It is difficult enough for the therapist to break though the inhibitions to get at the client's emotions; with an added barrier of tranquilizers this is often impossible" (Ramsay, 1979, p. 231). Medication dulls the capacity to experience emotions. Of course, emotional expression is key to extinction of conditioned fears and anxieties.

The therapist should invite the loved ones to come in with the client. This is useful not only to elicit the help of those people who are closest to the client, but also to allow the therapist to observe the dynamics among these people. Sometimes a "significant other" might serve as a co-therapist. On the other hand, relations between the two people might be such that the therapist would instruct the client to not inform the third person what is happening in the therapy sessions.

People who live with the bereaved have to be forewarned that a change in the behavior of the client will also affect their lives. That is, if a widow has been depressed for three years following the death of her husband, her children need to be informed that they can expect a change in their home life; hopefully a change for the better, but a change nevertheless.

Ramsay (1979) gives the example of a divorced 22 year old woman who had met her second husband while grieving the death of her young son through meningitis. Her second husband was a psychologist who adapted very well to her depression. Unfortunately, after the young woman improved due to implosion therapy, the husband was no longer able to deal with her. They married soon after therapy, but separated two years later despite marital therapy.

Prior to therapy, the partner also has time to ask questions of the therapist and may be invited to be treated along with the patient. The relatives are asked if they have any questions and most frequently they will ask what to do if the person undergoing therapy starts acting strangely. Should they ask questions about what is bothering the person who is in therapy? Ramsay answers that the significant others can ask what is wrong, but to allow the person who is undergoing therapy to decline to respond.

The physical setting for therapy is also important. A dark room facilitates crying more than a light room. The room should be soundproof to allow for screaming and the chairs should be comfortable because the sessions are long (Ramsay, 1979).

The length of the sessions may vary (Ramsay, 1976, 1977a, 1977b, 1979), but is is best to set aside two hours for each session. Two hours allows for one and one-half hours with the client and a half hour of rest for the

therapist between sessions. Some therapists go as long as six hours per session. The traditional 50 minute therapy is too short.

Clients differ in the amount of time between sessions. Generally three per week is the most any client can handle. If the client tries to break appointments or complains of moving too fast, then the appointments are too close together (Ramsay, 1979). The therapist should not go on vacation during this therapy because the client usually gets worse before getting better and it is not fair to a client to be left when feeling so dejected. During this treatment suicide is always a possibility and the therapist needs to be available.

When the first therapy session begins, the client is likely to feel nervous. Rather than wasting time talking about the client's feeling about the therapy, it is better to just begin (Ramsay, 1979). During the first session the client is asked to tell the whole story of how the death occurred, what the situation was like before, during, and after the death.

A therapist listening to these stories about the death can speculate as to areas where the bereaved has had problems. For example, if a widow relates the story that she went out for dinner and when she returned her husband was dead, it might be that she feels guilt about leaving him

when he was dying. This hunch is called an hypothesis which can be checked out in later sessions.

After the story is completed, the therapist can ask for clarification or ask that parts be repeated. The therapist wishes to evoke emotionality (Ramsay, 1979). For Ramsay, emotions need not be verbally expressed by the client. Any form of expression such as pacing around the room, rocking back and forth, crying, biting nails, or screaming is acceptable. The important thing "is to be able to elicit the feelings and to hold them as long as is necessary to get extinction" (Ramsay, 1979, p. 241).

If no emotions are expressed, the therapist should pursue a sensitive area until crying or some other appropriate behavior presents itself and is extinguished. For example, the therapist might say:

> The nurse only allowed you one minute to be with his body after he died, before bustling you out of the room. Now, if you heard that that had happened to someone else, would it surprise you if that person became angry with the nurse? No, it wouldn't surprise you. You can accept on an intellectual level that the anger in that situation is a possibility? But you neither feel nor felt anger? Okay, let's go back to the situation and recreate it not as it went but as you would have liked it to go. The nurse tells you to leave, but you now refuse. Say to her, "Nurse, that was my son, he's dead now and will soon be buried; I surely deserve a little time with him; I've got so little left, please don't send me away so soon." But she did send you away. You had only one minute with him and now he's gone forever. That nurse took him away from you before you had time to say goodbye. If you could see that nurse again what would you like to say to her? (Ramsay, 1979, p. 235).

In the case of Mrs. S. (Ramsay, 1976), she was told to close her eyes and imagine her husband, describe him, and

to state that he is dead. This did not work because Mrs. S. thought that her husband was still in the room with her. The therapist then instructed Mrs. S. to tell Mr. S. to go away. This did not work because he refused to leave. She carried on fights with her husband, trying to get him to leave.

Finally, the therapist instructed her to fight Mr. S. with his help. Mrs. S. had a violent reaction and finished the session with the mental picture that Mrs. S. had killed the therapist who was now laid out in a coffin. This verbal and mental fight with the therapist and Mrs. S. pitted against the imaginery Mr. S. went on for a period of two weeks for 1-1/2 hours per day. After that period of time, Mrs. S. finally got her husband to go away for a short time, but this caused severe depression and anxiety. She wanted to kill herself and her child. Mrs. S. had to be physically restrained from leaving the hospital, from ending therapy, and probably from suicide.

Within a few days, ready for more therapy but depressed, she continued therapy. Breaking down of denial took weeks and was filled with aggression, guilt, and anxiety. Aggression against the therapist, the hospital, her child and herself continued for weeks. She was asked to remember the details of her last fight with Mr. S. before he died.

After six weeks Mrs. S. wanted to see her child again although she was very anxious about this event. She was allowed to go home alone. This was a mistake. The therapist should have gone with her for support and to force prolonged exposure. The therapist went home with Mrs. S. the next time she was released from the hospital. The therapist forced her to clean out the closet and to remove Mr. S.'s personal belongings. At this point recovery became rapid and she again wanted to interact with other people.

Mrs. S.'s intensive therapy time in two months totalled 60 sittings of 1-1/2 hours average length and a full time nurse for four weeks (Ramsay, 1976). She suffered a relapse a few months later due to the flu and was depressed for a week or two. She experienced another short relapse when her two cats died. After one year she became suicidal because of an unrequitted love. Supportive therapy once every five weeks was prescribed until she remarried (Ramsay, 1976).

In general, new sessions can begin with inquiries about things that have happened since the last session, but in bereavement therapy it is important to stick to the main issue of the loss at hand. The clients will try to avoid dealing with the loss as they have done for years. So, the therapist has a difficult task of keeping them on the subject (Ramsay, 1979).

Denial can take the form of not believing that the loss has happened or can take the form of not feeling emotions. Whatever form denial takes, it is the task of the therapist to probe until appropriate emotions are experienced so that extinction can take place.

If the client is beginning to express anger, the therapist should probe for anger rather than another emotion such as sorrow. If the client is expressing guilt, the therapist should probe for guilt. It is counterproductive for the therapist to go after an emotion when the client is concerned with a different feeling (Ramsay, 1977b, 1979).

During therapy it is often wise to remain silent so that the patient may express feelings freely. As long as the client works, the therapist, even if silent for long periods, is also working. Other clients become upset if the therapist is not talking with them. The rule is that, "flexibility and sensitivity are an integral part of this type of therapy, as with every other" (Ramsay, 1979, p. 238).

Sometimes the client cannot concentrate, blocks, and refuses to talk about a certain event or feeling. The therapist can continue to bring up this blocked area, but until the client is willing to deal with it, he/she will avoid the subject and no amount of probing by the therapist will elicit discussion of it (Reever, 1974; Ramsay, 1979).

Therapy is completed when clients can express that they feel physically and mentally better. They are able to look at photos of the deceased or to discuss memories related to the dead person without crying or becoming upset. "One client reported that the deceased was no longer directly in front of her, blocking every thought and movement, but had moved to one side so that she was now free to move forward" (Ramsay, 1979, p. 243).

In summary, Ramasy (1979) uses a type of flooding whereby the client is presented with stimuli which bring forth painful emotions related to the bereavement. These emotions are brought forth again and again until extinction takes place (Ramsay, 1976).

2. Beck's cognitive therapy for depression

Experimentation with depressed outpatients has shown that cognitive therapy is more effective than pharmacotherapy (Imipramine) in relieving depressive symptoms. As measured on two depressive inventories, 78.9% of the patients in cognitive therapy showed statistically significant improvement as compared with 22.7% of pharmacotherapy patients who showed improvement (Rush, Beck, Kovacs, & Hallon, 1978). Previous clinical experimentation has shown cognitive therapy used on a short-term basis to be an effective way to treat depression (Beck, 1963, 1964).

Cognitive therapy is based on the idea that people behave in response to how they perceive their experiences (Beck, 1963; Rush & Beck, 1978). The various behaviors of depressed people such as hopelessness, crying, and suicidal thoughts are a response to faulty cognitive interpretations of what is happening.

> As a result of certain maladaptive cognitive schemas, the depressed patient tends to regard himself, his world, and his future in a negative way. This negative cognitive triad is evident in the way depressed patients systematically misconstrue their experiences and in the idiosyncratic content of their ideation (Rush & Beck, 1978, p. 484).

Specifically, "the theme of loss in terms of personal attributes, expectations, and interpersonal relations permeates the thought content of the depressed patient" (Rush & Beck, 1978, p. 484).

Cognitive therapy is a short term behavioral process (usually 20 sessions) which occurs in three steps (Rush & Beck, 1978). First the therapist helps the clients to identify their faulty thinking and incorrect belief systems. Depressed people incorrectly believe that their loss is somehow due to their own insufficiencies (Beck, 1974). These people spend a large amount of their time thinking about how they are "inferior, destitute, deserted, unloved, or physically deteriorated" (Beck, 1974, p. 135).

Because depressed people have a negative view of themselves, they tend to perceive their ongoing experiences

in a negative way. They also see no hope for the future (Rush & Beck, 1978).

In general, depressed people make five cognitive errors in thinking which must be uncovered by the therapist (Rush & Beck, 1978). The first of these errors is arbitrary inference which refers to drawing conclusions when inadequate evidence or no evidence exists to support that conclusion. For example, people may think that their friends do not like them anymore because they have not telephoned in two days. Actually, there is insufficient evidence to support this conclusion.

Selective abstraction is another area of cognitive thinking in which one insignificant detail is taken from an entire situation and blown out of proportion. For example, a depressed woman went to visit her daughter who had just had surgery in the hospital. The girl asked her mother not to sit on the bed and the mother became very upset to think that her daughter would view her as stupid enough to sit on the bed of a person who had just had an operation. The depressed woman interpreted the remark to mean, "Mother, you are stupid."

Overgeneralization is the process of drawing a generalized conclusion from a single incident. For example, a depressed woman might never invite friends over to her home because they were unable to come once. She might

conclude that they did not want to visit her and would never come.

Magnification and minimization are errors in evaluation which cause inaccurate conclusions to be drawn. Magnification occurs when a small problem becomes overwhelming. For example, a woman might become immobilized at the idea of having to clean the house. Rather than looking at the job in small parts such as washing the dishes, or dusting the furniture, she thinks of the whole task. She feels that the job is too big for her to ever finish, so she doesn't do anything. Minimization is another common error in the thinking of the depressed person. If depressed people are complimented, they often find a way to diminish the importance of the compliment. For example, they might think that the person giving the compliment was doing it only to procure a favor or the person giving the compliment didn't really understand the situation.

Finally, personalization is the faulty process through which people relate external events to themselves when they actually do not apply. For example, a depressed grieving man may be convinced that he has the same illness which caused his wife's death, although medical check-ups found him to be free of the disease.

In order to pinpoint the faulty thinking of clients, the therapist asks questions about what explicit situations or comments meant to the clients. In answering the

questions, the clients should be able to see their faulty thinking.

The second stage of the cognitive treatment for depression is to logically analyze this faulty thinking and themes to substitute more reality-oriented interpretations. For example, such a theme might be "expecting to fail" or "reading rejection" into certain situations.

> The therapist helps the patient to see that such a belief may not necessarily reflect reality. For example, the therapist would use logic, persuasion, and evidence from the patient's current and past functioning to get the patient to view a belief (e.g., "I am unable to learn") as an idea or hypothesis requiring validation rather than as a belief (Rush & Beck, 1978, p. 206).

The third step is to have the patients learn how to solve their problems through practice assigned in the form of homework. The clients are assigned small tasks so that they can learn to feel successful and so they can adopt a positive self-concept. In short, the point of this therapy is to realign the thinking of the depressed patients with reality.

Sometimes a combination of chemotherapy and cognitive therapy is used. The drugs help to alleviate physical symptoms so cognitive changes can be made (Rush & Beck, 1978).

Techniques of the Behavioral Therapist

In addition to flooding (Ramsay, 1976, 1977a, 1977b, 1979) and cognitive therapy (Beck, 1977, 1979) for

depression, other techniques may be used by behaviorists to help the grieving client.

Gestalt techniques such as fantasy and third chair may be used (Ramsay, 1979). For example, the therapist might say, "Imagine that Ralph is here in the room with us. What would you like to say to him?" Gestalt techniques are particularly useful when the client has denied the loss of the loved one. The client frequently feels the presence of the deceased and may actually hallucinate that the person is still present (Ramsay, 1976, 1979). In such cases, since the dead person is there anyway in the mind of the client, it is easy for the client to use the empty chair technique by imagining that their loved one is sitting with them in the room. Ramsay instructed one of his clients who was feeling guilty to, "Imagine that John is present, tell him that you did things wrong, tell him what you did, ask him if he can ever forgive you" (Ramsay, 1979, p. 239). This technique helps to extinguish the guilt and to allow the clients to forgive themselves for circumstances surrounding the deaths which they perceived to be their own fault.

Another technique is to use conversation which carries out the emotion being expressed. For example,

> Tell him how much you miss him, tell him how often in the mornings breakfast isn't the same any more; toward six o'clock you feel the pain of knowing he won't be walking through the front door. Tell him that dinners are quiet and empty and the food doesn't taste good any more. The evenings are so long, but you don't want to go up to the cold, empty bed. Tell him how long and

> bleak the weekends are, that you've tried to keep his garden going but that it's now in ruins . . . (Ramsay, 1979, p. 239).

Looking at photos usually releases emotions, especially crying. Although clients may have the photos displayed at home, when they see them in a different setting, such as the counseling room, they become very upset (Ramsay, 1977b).

Behaviorists may also use linking objects. Linking objects (Volkan et al, 1976) are items which are never touched. They are very personal reminders of the deceased which have been locked away for as long as 50 years. They have the power to evoke strong emotional reactions, usually of a negative type, and are regarded by the clients as magical. A linking object may be a flower, a picture of the loved one, a locket, or any other trivial item.

During therapy, clients are asked to be aware of linking objects and to bring them into the therapy session. When linking objects are discussed and faced, the negative emotions surrounding the object escapes and only positive feelings remain (Ramsay, 1979).

Criticism of Behavioral Grief Counseling Therapy

One criticism of behaviorism is that it does not deal fully with the problems of depression and grief (Franks & Wilson, 1976; Ramsay, 1976). Ramsay (1976) has listed the only behaviorists he could find who addressed these topics at all. They are Burgess (1968), Lazarus (1968), Lewisohn

(1968), Leberman & Raskin (1971), McAuley & Quinn (1971), and Wolpe (1971). "The theoretical behavior therapy articles on depression barely touch on the effect of bereavement, and much serious work will have to be done in order to understand depression and mourning, and the differences and similarities between them" (Ramsay, 1976, p. 235).

Ramsay's therapy has certain limitations and problems. First, not all therapists could handle the emotional strain of the therapy. Also, it is useful for a limited clientele (Ramsey, 1979). As previously mentioned, this therapy is never used with clients who have been grieving less than a year. The client must also be strong enough emotionally to endure the stress of this treatment and have supportive friends and/or family who can help the client physically and emotionally during the treatment. Also, the client must be young enough and healthy enough to start life anew.

> A person with a long history of psychiatric problems prior to the loss would probably not be able to withstand the stress of therapy; a widow with three young children and no close family to fall back on would not be a good candidate . . . a widow of 65 could profit more from a supportive contact than a flooding approach (Ramsay, 1979, p. 229).

The therapist must make a clinical judgment to decide whether or not a client meets these qualifications.

Additionally, this therapy can be dangerous for some patients. The therapy increases the risk of suicide during the beginning and the middle stages of treatment (Ramsay,

1979). Suicidal clients must be hospitalized during this therapy. The client must know how the therapy will progress, and be willing to accept the pain of the treatment in hopes of feeling better after having faced the loss through the process of therapy.

Skinner's Walden Two has been severely criticized as being impractical. "Dr. Skinner's characters talk far too much about ethical abstractions and see far too little to show the reader why Walden Two is utopia, nevertheless the author has invented a fascinating--often fascinatingly abhorrent--community" (James & Brown, 1949, p. 777). A human technology to partially control emotions seems impractical on a large scale in modern American society.

Beck has written only on depression and not on grief in general. Further research is needed to determine the link between depression and grieving.

In summary, behaviorists have offered techniques for dealing with some bereaved people. They have not presented a unified process for the treatment of all bereaved people who seek treatment.

Chapter Summary

This chapter has discussed how behavior therapists have approached the counseling of bereaved clients. A review of the literature has shown that B. F. Skinner has dealt with the problems of individuals as the fault of

society in general. In a supportive society, abnormal grief reactions would not occur.

Many behaviorists such as Beck have treated the symptoms of the bereaved client as they appear, rather than studying the entire process of grieving. Beck has treated depression which may occur in varying intensity and duration during grief. He has applied cognitive therapy to the treatment of depression.

Ramsay (1976) was the first behaviorist to study the psychoanalytic model for grieving and to offer modifications to it. He has successfully treated bereaved people using flooding techniques.

Abnormal bereavement develops as phobias do, through the process of avoidance. Previously neutral stimuli takes on new meaning and anxiety builds up. Therapy must be geared toward extinction, that is, emotions must be confronted until they decrease in intensity.

Behaviorists have begun to consider the problems of the grieving client, but they have only started to explore the potentials of behavior therapy for these clients.

CHAPTER V

DISCUSSION

Chapter V of this dissertation is divided into three parts: a summary of the three theoretical approaches to grief counseling, conclusions drawn from the four prior chapters, and implications for counseling and for further research. The Chapter outlines patterns (Barzun, 1970), similarities and differences, which can be noted among these three theories concerning the meaning of life, the process of grieving, and the counseling procedures which could help the bereaved client. The hypothesis of this study, that the processes of treatment of all three theoretical approaches to grief counseling are similar despite their diverse origins and different views of the nature of man, is also discussed.

Summary

This dissertation reviews how the psychoanalytic, the humanistic, and the behavioristic theories of counseling have been applied to the treatment of the grieving spouse. The method of this dissertation is historical research. The study of the psychoanalytic theory is based on the works of S. Freud, E. Lindemann, C. Parkes, P. Marris and J. Bowlby.

The humanistic theory is grounded in the writings of V. Frankl, R. May, A. Maslow, and C. Rogers. Behavioristic theorists are represented by B. F. Skinner, A. Beck and R. Ramsay.

The historical analysis of each theory includes a developmental overview and review of existing literature, an analysis of the mourning process, the goals of the therapist, the process of treatment, techniques of the therapist, and criticism of the currently used therapeutic process. Both normal and pathological grief are discussed (Parkes, 1972).

Chapter II of this dissertation deals with the psychoanalytic study of mourning and melancholia which began with Freud. For the purpose of this dissertation, Freud's writings on these subjects have been divided into four groups (Hoffman, 1979): (1) the topographic model of the mind (Freud, 1913/1955, 1915/1957, 1917/1957) in which all statements about death focus on the unconscious; (2) the concept of the death instinct (Freud, 1920/1955, 1926/1959, 1933/1964); (3) the development of the structural model (Freud, 1923/1961, 1933/1964); and (4) the "existential" point of view restated and clarified in "On Transcience" (Freud, 1916/1957).

Although critics dispute whether or not Freud's ideas represent a unified theory of mourning or if they are only a collection of ideas, there is general agreement that

Freud's speculations were the creative impetus which began a theoretical and clinical study of the grieving process and the treatment, when necessary, of the grieving client.

After Freud, other psychoanalytic theorists have studied grief. Included in this list are E. Lindemann, J. Bowlby, and C. Parkes. Lindemann studied 101 bereaved people including survivors of the Coconut Grove Fire in 1944 in New York. This work was the first of its kind in that he scientifically studied a large number of adults who had experienced the death of a loved one. Lindemann drew attention to the fact that common features are often shared by grieving people. He also recognized "anticipatory grief" and isolated six traits of abnormal grief.

John Bowlby (1961, 1963) was the first to explain mourning in a normal population using psychoanalytic terms. Bowlby bases many of his ideas about grief on his own work with the grieving child (Bowlby, 1961). Bowlby (1980) describes the grieving process in four stages: numbing, protest, despair, and detachment.

Colin Parkes who practices psychiatry with Bowlby at the Tavistock Institute in London, has contributed to grief theory by performing clinical case study research to find physical and emotional patterns in the grieving client. Parkes' work is important because he elucidates the major stages of grief by expanding on the work of Bowlby, Lindemann, and Marris (Solomon, 1977).

Psychoanalytic grief literature either explains the grief counseling process as it relates to Freud's ideas regarding the structure of the mind (Freud, 1912; Klein, 1940; Bowlby, 1963) or describes the grieving process (Lindemann, 1944; Marris, 1958; Parkes, 1971). However, all authors agree that there is a common grief process and that the type and intensity of reactions will vary depending upon the relationship that the survivor had with the deceased (Solomon, 1977).

Humanism, the topic of Chapter III, is a philosophical orientation which stresses the importance of human beings. The principles of humanism were molded into a framework for counseling by Abraham Maslow. Maslow's principles were called the "third force" in psychology, the first and second forces being psychoanalysis and behaviorism (Goble, 1971; Maslow, 1974).

All the humanists who are discussed in Chapter III have written about the meaning of life and death and how people can survive their problems and, in fact, learn from them (May, 1969, 1975; Frankl, 1971, 1978; Maslow, 1974; Rogers, 1980). In the fact of tragedy, people have the freedom of choice as to how they will respond (May, 1953). Further, people have the inner strength to respond positively to any situation no matter how difficult it might be.

Humanists do not specifically deal with the problems of the grieving spouse because they view all problems as

being essentially the same. That is, a crisis situation necessitates a response. That response may be a destructive action or a positive coping action which will result in personal growth. Abnormal grieving develops when people try to avoid the pain of grieving, a destructive response. A constructive response to losing a loved one is to squarely face the situation and the emotional readjustment necessitated by the death (Frankl, 1971). The goals of the humanistic grief counselor are: (1) to help clients learn to accept suffering; (2) to help clients find meaning in their suffering; (3) to help clients to begin to find interests and activities.

Although humanistic counseling theory is criticized as being too vague and unrealistically optimistic (Child, 1973), humanists have dealt with questions that have long been pondered by humankind. The answers to these questions that humanists offer cannot be scientifically validated, but humanistic counselors do offer the grieving client one indispensable ingredient--hope. According to Viktor Frankl, the people in the concentration camps who survived were not necessarily the strongest or the smartest. The survivors were the ones who had hope for the future (Frankl, 1959).

Chapter IV discusses how behavior therapists have approached the bereaved client. B. F. Skinner (1948) described in Walden Two how grieving the loss of a loved one is a normal process which runs smoothly in a society where

"behavioral engineering" has been instituted. In this type of environment, people are supportive of each other and abnormal grief reactions do not occur.

Some behaviorists, such as Aaron Beck (1977), describe how isolated symptoms which sometimes occur in the bereaved person may be treated. Beck deals specifically with depression which may occur in varying intensity and duration during grieving. Cognitive therapy was developed by Beck to treat depressed people.

Ramsay (1976) was the first behaviorist to apply behavior therapy for use specifically with grieving people. This therapy is based on the idea that abnormal grieving develops as phobias do, that is, through attempts to avoid painful stimuli (Esyenck, 1967). Therapy is geared toward extinction of formerly repressed emotions. Ramsay's flooding therapy may be used for only a few carefully selected clients. It is used only after one year of bereavement and when the grieving reaction is clearly abnormal. Because Ramsay's treatment is the only behavioral technique specifically designed for treating bereaved people, it is described in detail in this dissertation.

Behaviorists have developed a treatment approach for grieving people. They have, however, only begun to examine possible solutions to this common counseling problem (Franks & Wilson, 1976).

Several ideas are accepted by proponents of all theories. These ideas are as follows:

1. Grieving people often share many common patterns of behavior and emotions; however, each person expresses grief in a unique way.
2. The grieving process is a painful experience.
3. Active grieving normally ends one to two years after a loss.
4. The characteristics of a grieving spouse sometimes appear in a predictable order or in stages. However, the unique qualities of each individual cause regression among and frequent changes in the clinical picture.
5. The difference between normal and abnormal grieving is one of duration and intensity.
6. Attempts to avoid the pain of grieving result in added pain and possible neurosis.
7. Most grieving people do not need to seek therapy. Significant others are usually able to provide adequate physical and emotional support.
8. When therapy is necessary, the therapist must be supportive.
9. The goals of grief counseling center on separation from the deceased person,

reorganizational issues, and the release of repressed emotions such as anger and guilt.

10. The five steps of the grief counseling process are as follows:
    a. establish the relationship
    b. review of events surrounding the death
    c. insistence on the reality of the death
    d. search for patterns
    e. reorganization/action
11. Counseling techniques may be adopted from any framework if beneficial for a specific client.
12. Additional research into the problems of the bereaved spouse needs to be done.

In general, it can be said that all three theoretical frameworks have contributed in different ways to the body of grief counseling literature. The psychoanalytic theory defines the process of mourning. The humanistic theory concentrates on questions concerning the meaning of life and death. The behaviorists stress the treatment aspects of grief counseling.

Conclusions

Comparison and Contrast of Reviews of the Literature

One way to compare the three theoretical frameworks is to analyze the amount of grief literature published by the writers reviewed in the dissertation. Table 2 shows the number of publications listed in the bibliography of this

Table 2

Publications Dealing with Grieving Cited in this Dissertation

Author	Number of Publications	Dates of Publications
Psychoanalytic theory		
Freud	14 books	1895-1933 (38 year span)
Lindemann	1 article	1944
Marris	1 book	1958
Bowlby	3 articles	1962 to present (22 year span)
Parkes	1 article 2 books	1972 to present (12 year span)
Humanistic theory		
Frankl	7 books	1955 to present (29 year span)
May	7 books	1950 to present (34 year span)
Maslow	6 books 3 articles	1943 to 1969 (26 year span)
Rogers	3 books (on counselor/ client relationship	1951 to present
Behavioristic theory		
Skinner	1 book 2 articles	1948 to 1983 (33 year span)
Beck	4 books 4 articles	1974 to present (10 year span)
Ramsay	4 articles	1975 to 1979 (4 year span)

study by each author and the dates of those publications. It should be noted here that the grief literature cited in this study does not necessarily include all the publications of these authors. Several observations can be made for this table. Clearly, Freud published on the topic of mourning before any other author. He also published approximately twice as much literature as any one else in the field, despite the fact that six other writers have been in print for over twenty years. According to Freud's primary biographer, Jones (1953), Freud was more concerned with death than all but two other men in the history of civilization, Sir. Thomas Brown and Montaigne. When Freud's father died in 1894, he experienced "the most poignant loss" in his life (Freud, 1908/1959, p. xxvi). This event caused him to begin his own self-analysis and to subsequently produce a wide diversity of literature including numerous writings on death and mourning (Jones, 1953). Freud's constant preoccupation with death (Jones, 1953), concern for his personal health (Fleiss, 1906; Clark, 1980) and his feelings regarding his father's death (Freud, 1960) made psychoanalytic ideas interwoven and inseparable from his study of mourning and death.

The two humanistic writers who have written the most literature on suffering and grieving are Frankl and May. A person reading these works by Frankl and May would observe that Frankl's books contain more chapters specifically

devoted to suffering than those by May or any other humanist. Frankl's primary concern is with adapting to tragedy and growing from it. Frankl uses his concentration camp experiences to show others that people can control how they perceive any situation.

Table 2 shows that the behaviorist who has published the most on this topic is Beck. However, Beck's literature is specifically on depression. Ramsay has written the most behavioral research solely devoted to treating bereaved people.

Some writers from each of the three behavioral frameworks have written on the topic of grief, among other subjects, throughout their lives. These men are Freud, Bowlby, Parkes, Beck, Frankl, May, and Maslow. Other theorists are known for one major work on bereavement. These are Lindemann (1944) for his work with the survivors of the Coconut Grove Fire, Marris (1958) for his study of London widows, and Skinner (1948) for Walden Two which describes a utopian society.

Two theorists, Skinner and Rogers, who rarely discussed the problems of grieving in their younger days, are now publishing articles which review their lives and discuss humanistic questions dealing with the meaning of life and death (Rogers, 1980; Langone, 1983; Skinner, 1983). For example, Rogers (1980) ponders how he will meet death, whether or not he will be fearful. It is interesting that

Freud also speculated, in his later years, about his final destiny. As an older man he became open to the possibility of life after death (Jones, 1953).

It is also clear from Table 2 that most of the literature on grieving other than Freud's has been written after 1950. Skinner's Walden Two in 1948 mentions loss on two pages of the entire book and Maslow did not write about the value of coping with suffering until after 1950. Only Lindemann (1944) did a systematic study of grieving people prior to the 1950's. Several people have proposed that dealing with grief has become more of a problem in recent years and that the grief literature reflects this problem.

The attitude of Americans toward death has been changing over the last fifty years (Shneidman, 1976). Generally, death anxiety has increased and people are experiencing more difficulty with grieving than they had in earlier times (Gorer, 1965). Several factors have contributed to this change. One change is that the family no longer participates in the dying process as they had in previous ages. In the past, families were able to participate in the death of their loved ones on a more intimate level. Now most people die in hospitals and funeral directors take care of the actual burials, a task formerly done by the family.

In former days, when a spouse died, the widow or widower often moved in with other family members or at least

had them nearby. Due to today's mobile society, the families are often not present to offer the surviving spouses the support that they need during the first year of bereavement.

Another major cause of a new fear of death is what Gorer (1965) calls, "the pornography of death". During the last 50 years, television, movies, and newspapers have inundated the western world with violence and stories of death. This media violence permeates American life and increases people's fear of possible evils which could befall them.

The threat of nuclear destruction is another reason that many people are experiencing anxiety about death. The menace of nuclear war shakes humankind's beliefs about immortality. Formerly people could believe that they would live on after their deaths through their children (Toynbee, 1968) or through their work (Skinner, 1983). Unfortunately, nuclear war would eradicate these ways of gaining immortality. This philosophical problem was experienced by the Japanese people after World War II (Lifton, 1967).

So, these causes and others have precipitated a growing fear of death in the United States. When people fear death, they try to ignore it, making it difficult for bereaved people to openly express their grief, a necessary part of recovering from the loss of a loved one. In order to help people adjust to the loss caused by the death of a

loved one, these three theoretical frameworks for grief counseling have been developed.

Despite the increase in literature on this topic since 1950, critics of all three frameworks have called for more study of grieving people (Franks & Wilson, 1979). It seems that study of this subject has just begun.

Comparison and Contrast of Descriptions of the Mourning Process

In Chapters II, III, and IV of this dissertation, the sections concerning the description of the mourning process were organized around five questions. What are the characteristics of the grieving spouse (Table 3)? Do these characteristics appear in stages (Table 4)? How long does the grieving process last (Table 5)? What is the difference between normal and abnormal grieving (Table 6)? And, is grief an illness (Table 7)? Each of these questions are discussed in turn in the following section.

Characteristics of the Grieving Spouse

From Table 3 it is immediately clear that many similarities exist between the psychoanalytic picture of the bereaved client and the behavioristic perspective. Ramsay (1979), a behaviorist, totally adopts the psychoanalytic analysis of bereavement. He has no problems accepting it as a basis for his counseling theory. One could ask why, if Ramsay accepts the psychoanalytic analysis of the problem,

Table 3

Characteristics of the Grieving Spouse

Psychoanalytic theory

a. Painful dejection and/or anxiety

b. Physical symptoms

c. Preoccupation with thoughts of the deceased

d. Taking over the identity and/or activities of the deceased

f. Hostility, anger, and/or guilt (oscillation of feelings toward the deceased which can lead to anger or guilt (Freud, 1913/1955)

g. Change in activity level

h. Reorganization (Freud, 1913/1955; Lindemann, 1944; Parkes, 1972; Bowlby, 1980)

Humanistic theory

a. Grieving person is trying to find meaning in suffering

b. Grieving person has an opportunity to grow from a painful experience (Frankl, 1967, 1975; May, 1969; Maslow, 1970; Rogers, 1980)

Behavioristic theory

a. Ramsay (1979) takes clinical picture of the bereaved spouse from psychoanalytic theory

Table 3 (continued)

b. Bereavement can be viewed as a type of depression. The characteristics of depression which occur in varying degrees of severity are:

1. A change in mood: sadness, loneliness, apathy
2. Regressive and self-punishing wishes to escape, to hide, or to die
3. Negative self-concept
4. Physical changes: Insomnia, loss of appetite, etc.
5. Change in activity level, either more or less active (Beck, 1977)

he does not use the psychoanalytic treatment. Ramsay does not provide the answer to this question. Apparently, he was trained as a behaviorist. Yet, he has an open mind with regard to other research which has been carefully done.

Beck's characteristics of the depressed person are also very similar to the psychoanalytic characteristics. In fact, all of Beck's traits of the depressed person are found on the psychoanalytic list of the qualities of the grieving person. The psychoanalytic list includes a few items specifically related to bereavement. These are preoccupation with thoughts of the deceased, taking over the identity and/or activities of the deceased, oscillation of feelings toward the deceased, and reorganization. This observation points out that a relationship does exist between depression and mourning. It lends credence to the idea that bereavement is a specific type of depression (Ramsey, 1976; Beck, 1977). The exact relationship between mourning and depression is unclear. Are mourning and depression separate and distinct clinical events as Freud (1913/1955) maintained? Is bereavement a specific type of depression (Ramsay, 1976; Beck, 1977). Or is depression only one phase, stage, or component of bereavement (Ramsay, 1979; Parkes, 1972; Bowlby, 1980)?

It can be seen that Ramsay changed his opinion on this question. When he first published in 1976, he stated that bereavement was a type of depression. By 1979, he had

adapted Bowlby's "stage" theory to his own "component" theory. Depression appears as a component of bereavement. In short, the relationship between bereavement and depression is unresolved.

The humanistic view of the bereaved person is very different from the other two. None of the humanists refers to the psychoanalytic research as a valid or invalid approach to bereavement. Their emphasis of study centers on the importance of hope, finding meaning in tragedy, and growing from pain. Rather than analyzing the components of grieving as the other theorists have done, humanists accept the fact that pain is a universal event, so common that it need not be dissected. They choose instead to center on the means towards growth (reorganization). Psychoanalytic theorists think that reorganization occurs naturally when the stages of grief have been worked through. That is, reorganization is a reward for the pain of bereavement. Humanists, on the other hand, have chosen to center their attention on the actual reorganization process itself. That is, they study the intellectual process necessary to facilitate reorganization. The fact that humanists study the most hopefilled stage of bereavement is consistent with the entire humanistic philosophy which centers on personal growth through love, suffering, and work (Frankl, 1967).

In summary, an analysis of all three theoretical views of the characteristics of the grieving spouses reveals

that they are all compatible. The psychoanalytic theorists offer the most complete scenario of the bereaved person. Humanists have chosen to analyze the interpersonal struggle toward reorganization. Some behaviorists see bereavement as a special type of depression, but others wholeheartedly adapt the psychoanalytic research (Ramsay, 1976). In summary, the psychoanalytic research looks at the entire bereavement process. Humanists and other behaviorists, such as Beck, study specific parts of the grieving process.

Stages of Characteristics of the Grieving Spouse

It can be seen from Table 4 that the early members of the psychoanalytic school (Freud, Marris, and Lindemann) did not attempt to put the characteristics of grieving people into stages. This was first done by Bowlby and Parkes. Also, the humanists did not describe stages of grieving. Ramsay has objected to the rigidity of the idea of stages because it ignores the individuality of grief and the temporary regression among "stages" common to bereavement. Ramsay developed the idea of components of grieving.

This difference of opinions between Bowlby and Ramsay is reminiscent of two other writers who studied grief reactions during Freud's time. Darwin (1872), who studied the comparative facial expressions of man and animals, observed that grief has universal elements which may be recorded. Another writer, Shand (1920), used the works of English and French authors to isolate the main

Table 4

Stages of Characteristics of the Grieving Spouse

Psychoanalytic theory

a. Freud (1913/1955), Marris (1958), and Lindemann (1944) describe characteristics but do not divide them into stages

b. Bowlby (1980) and Parkes (Glick et al., 1974) do list stages of grieving as follows:

   1. Phase of numbing that usually lasts from a few hours to a week and may be interrupted by outbursts of intense distress and anger.
   2. Yearning and searching
   3. Disorganization and despair
   4. Phase of greater or lesser degree of reorganization (Bowlby, 1980)

Humanistic theory

Not discussed

Behavioristic theory

Bowlby's (1980) theory modified from states of grieving to the idea of components of grief which do not present themselves in sequential order (Ramsay, 1979)

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characteristics of grief and concluded that grief is unique to each person. In short, Darwin points out the commonalities shared by grieving people, while Shand reminds us of the individuality of the loss experience. Similarly, Bowlby (1980) and Parkes (1972) have observed the universal elements of grief and have attempted to find a pattern in their occurrence. On the other hand, Ramsay (1979) reminds us that although common elements of grief can be found, the fact remains that each person is unique and will grieve in an individual way.

Only the psychoanalytic theorists have studied the question of the duration of bereavement (see Table 5). Ramsay, a behaviorist, has accepted Bowlby's research opinion that normal grieving lasts for 1-2 years. Lindemann found that his clients grieved for 6-8 weeks, however, his study lasted for only 8 weeks. Lindemann would have had no way of knowing if his clients had grieved longer. Marris studied widows after 1 year following the death of their spouses and found that many of them were still grieving. Parkes' (1974) study ended after the first year of bereavement when most widows felt that they were doing better. A similarity can be found among all these studies in that the authors felt that most of the grieving of their clients had stopped when their research ended. It seems that longer term research should be done to determine if the studies were limited and if normal bereavement actually extends for

Table 5

Length of Grieving Process

Psychoanalytic theory

a. Lindemann (1944) 6-8 weeks

b. Marris (1958) weeks - 2 years

c. Parkes (Glick, et al., 1974) most much better after one year

d. Bowlby (1980) 1-2 years

Humanistic theory

Not discussed

Behavioristic theory

Ramsay (1977b, 1979) uses psychoanalytic description, that is, 1 to 2 years

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a longer period of time. In other words, the time limitation of the studies may be giving an unrealistic picture of the duration of the grieving process.

The Difference Between Normal and Abnormal Grief

All three groups of theorists with the exception of Freud agree that the difference between normal and abnormal grieving is one of intensity and duration (see Table 6). To review, excessive duration and intensity are generally defined as follows. Active grief lasting more than one to two years is generally considered abnormal (Ramsay, 1976; Bowlby, 1980). Also, intense reactions, especially extreme anger, guilt (Freud, 1916/1957; Parkes, 1972) and clinical depression (Beck, 1977) are considered abnormal.

Freud (1916/1957) sees normal and abnormal grief as two separate processes (Solomon, 1977). Current thought (Glick et al., 1974) sees these two types of grief as being on opposite ends of a continuum with no distinct line of demarcation between them.

It seems that both positions have some merit. Freud's (1916/1957) position is that those who grieve abnormally have an underlying personality disorder. Current research (Vachon, 1982) has shown that people who have had emotional problems in the past are more likely to have a difficult time during bereavement. However, in the more modern view (Millon, 1969), all mental illness is seen as being on a continuum with normalcy at one end and with

Table 6

The Difference Between Normal and Abnormal Grief

Psychoanalytic theory

a. According to Freud (1916) normal grieving (mourning) is one process and abnormal grieving (melancholia) is another distinct process. Mourning occurs on a conscious level.

b. Excessive duration, that is, prolonged grief is a symptom of abnormal grieving (Freud, 1916/1957; Lindemann, 1944; Bowlby, 1961 ; Parkes, 1965, 1971, 1972; Glick et al., 1974)

c. Excessive degree of mourning especially excessive anger, self-blame, and guilt are characteristic of abnormal grieving (Freud, 1916/1957; Lindemann, 1944; Bowlby, 1916; Parkes, 1965, 1971, 1972). Guilt and anger can result in a variety of self-punishing activities including depression and physical illness (Glick et al., 1974)

Humanistic theory

a. Difference between normal and abnormal grieving is one of duration and intensity (May, 1950; Frankl, 1975).

b. Key feature in abnormal grieving is the blocking of sorrow (Frankl, 1965; May, 1969; Maslow, 1968).

Table 6 (continued)

Behavioristic theory

a. Difference between normal and abnormal grieving is one of duration and intensity (Beck, 1977; Ramsay, 1976, 1979).

b. Abnormal grieving grows from attempts to avoid grief (Ramsay, 1976).

profound mental illness at the other. Perhaps the difference between Freud and modern theorists can be reconciled by saying that the difference between normal and abnormal grieving is one of intensity and duration, but that excessive mourning often occurs in those predisposed to mental illness by inadequate coping skills (Carkhuff, 1967) and by possible underlying personality disorders.

Another striking similarity among these three theoretical frameworks is the agreement on how abnormal grief develops. Attempts to avoid the pain of grieving precipitate abnormal grieving. According to Freud (1916/1957), the libido of the surviving spouse establishes, "an identification of the ego with the abandoned object" (Freud, 1916/1957, p. 249). The loss of a loved one then becomes loss of the self. So rather than endure the pain of placing the libidinal energy formerly identified with the abandoned object, on a new object or interest, the surviving spouse who is grieving abnormally, continues to try to perpetuate his/her tie to the deceased (Freud, 1916/1957). This is a form of avoidance.

Lindemann (1944) and Parkes (1972) point out that a delayed grief reaction, another form of avoidance, is also an indication that an abnormal grieving process will ensue. Bowlby (1961), Frankl (1965), May (1969), Maslow (1967), and Ramsay (1976) also mention blocking (i.e., avoidance) of grief as a catalyst for an abnormal grieving process to

begin. In short, attempts to avoid the necessary pain of grieving only result in a longer and more intense grieving period.

Grief as an Illness

It seems that Bowlby (1961) and Parkes (1972), by discussing grief as an illness, are attempting to point out that grieving people need to be treated in a caring way by the people around them (see Table 7). They have been wounded and need to recuperate as one does from any injury. No one who advocates that grief is an illness puts forth the idea that all grieving people should seek professional help for their "illness".

Generally, if treatment is needed by the grieving client, then the term "illness" is introduced (Siggins, 1967). Society has a responsibility in general to be supportive of its grieving members (Skinner, 1948; Freud, 1916/1957; Frankl, 1975). A bereaved person's friends and family can be very helpful to the grieving client and thereby help eliminate the need for therapeutic intervention. Freud (1916/1957) states that psychoanalytic treatment of a spouse who is grieving normally is generally unhelpful and can be harmful.

Goals of Grief Counseling

The goals of grief counseling (Table 8) of all three theoretical frameworks can be divided into three groups:

Table 7

Grief Described in Terms of Illness

Psychoanalytic theory

a. Freud (1916/1957) grief is not an illness. It is a normal process.

b. Lindemann (1944), Bowlby (1961) and Parkes (1972) see grief as a normal process in which people often act as they do when they are physically ill. Society treats grieving people as they do someone who needs physical care. Therapists should to the same.

Humanistic theory

Frankl (1975), May (1975), Rogers (1980) all view grieving as a part of life which can be an opportunity for growth.

Behavioristic theory

a. Grief is not an illness unless it requires treatment (Siggins, 1967; Ramsay, 1979).

b. Clinical depression, which may appear in abnormal grieving, is an illness (Beck, 1967, 1977).

Table 8

Goals of Grief Counseling

Psychoanalytic theory

a. To help bereaved people to separate themselves from the deceased by breaking the bonds between them (Lindemann, 1944).

b. To help the bereaved adjust to new environments (Lindemann, 1944) and to form new relationships (Freud, 1917/1957).

Humanistic theory

a. To offer a supportive relationship which facilitates the other goals (Rogers, 1961, 1980).

b. To help clients find meaning in their suffering and to grow from this understanding (Frankl, 1965; May, 1953; Maslow, 1968; Rogers, 1980).

c. To help clients get outside of themselves (Maslow, 1971, 1972).

Behavioristic theory

a. To offer support during the acute phase of depression and/or bereavement (Ramsay, 1977b, 1979; Rush & Beck, 1978).

b. To strengthen the client's personality so that further set backs do not occur (Ramsay, 1979).

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1. Separation goals (goals for the client)
2. Supportive goals (goals for the therapist)
3. Reorganization goals (goals for the client)

All three theoretical frameworks speak of separation goals. The necessity of bereaved spouses to separate themselves from the deceased was first stressed by Freud (1916/1957). Lindemann (1944) also emphasizes this goal as does Ramsay (1976) in his aforementioned case study. Humanists (Frankl, 1965; Buehler, 1967) stress acceptance of the death as the sin a quo non of the separation process (Maslow, 1971, 1972).

Humanistic and behavioristic theorists stress the importance of the therapist offering emotional support to the grieving client (Rogers, 1951; Frankl, 1965; Ramsay, 1977, 1979; Rush & Beck, 1978). This support facilitates both separation and reorganization goals. Psychoanalytic theorists also view the relationship between the therapist and the client as being very important (Bowlby, 1980).

Reorganization and growth are the ultimate goals of grief counseling. Theorists from all three frameworks agree on this point. Advocates of the psychoanalytic school talk in terms of libidinal reinvestment in new objects (Freud, 1917/1957) and new environments (Lindemann, 1944). Humanists speak of helping clients to find meaning in suffering and to grow from this understanding (May, 1953; Frankl, 1965; Maslow, 1968; Rogers, 1980). Growth is movement

toward a better self, e.g., toward self-actualization (Maslow, 1972). Behaviorists speak of growth in terms of strengthening clients' personalities so that they are better able to cope (Ramsay, 1979). In other words, therapy should be a learning experience which can provide a means for coping with future crises.

In short, general agreement among all theorists exists that in grief counseling the therapist must strive to provide a supportive environment so that the clients are free to separate from the deceased and to reorganize their lives so that they have experienced personal growth despite tragedy.

Grief Counseling Process

As Table 9 on the grief counseling process reveals, many commonalities exist among the three theoretical frameworks. Five general concepts can be identified as part of the grief counseling process. These are the importance of the counselor-client relationship, review of the events surrounding the death, insistence on reality, a search for patterns, and some type of action and/or reorganizational response. In Table 9, a few open areas are apparent. For example, Beck (1977) does not list establishing a good relationship with the client as being a part of his three stage process. However, evidence could be given to show that Beck considers a good relationship imperative to his cognitive therapy. Similarly, a review of details sur-

Table 9

Grief Counseling Process

General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory	
			Ramsay	Beck
1. Importance of counselor-client relationship	Therapist empathic and open to client's loss (Corazzini, 1980)	Therapeutic relationship essential to change (Rogers, 1951)	Establish relationship (Ramsay, 1979)	
2. Review of details of death, before and after	Hypercathexis (Freud, 1916). Client talks freely about events surrounding death (Parkes, 1972; Bowlby, 1980)	Client relates loss. Therapist helps client to find meaning in suffering. All details need not be included (Frankl, 1978)	Review of details of (Ramsay, 1979)	

Table 9 (continued)

General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory	
			Ramsay	Beck
3. Therapist insists on reality	Insist on reality of death (Corazzini, 1980; Parkes, 1972)		Force realistic view of death (Ramsay, 1976)	Identify faulty thinking patterns. (Rush & Beck, 1978)
4. Search for patterns	Search for origin of feelings--review of past losses (Freud, 1916/1957)	Client explores attitudes to find non-useful patterns. Insights gained (May,		Analyze faulty thinking patterns (Rush & Beck, 1978)

Table 9 (continued)

General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory	
			Ramsay	Beck
5. Action and Reorganization	Expression of repressed emotions, especially anger and guilt (Parkes, 1972; Glick et al., 1974) other action not specified	Clients act on new insight (May, 1975)	Skills are learned so that regression does not take place.	Action Practice assignments learn how to solve problems (Rush & Beck, 1978

rounding the onset of a depression (e.g., the death of a loved one) would have to be reviewed to reveal faulty thinking patterns, Beck's first step for therapeutic change. The point here is that this table lists those items specified by each theory as being part of the counseling process. That is to say, the seemingly omitted items are probably considered important, although not primary.

Yet, some differences among these three theories can be found. One major difference is in the types of patterns which are searched out and in the way they are discovered. The psychoanalytic counselors look for patterns of feelings (Freud, 1916/1957). To find these patterns, they look into the client's past. Humanistic counselors look for patterns of attitudes (May, 1975). They consider the past and the present, but their eye is to the future. Behavioristic counselors analyze faulty patterns of thinking (Rush & Beck, 1978). They are primarily concerned with the present.

The action and/or reorganization phase of counseling also varies. The humanistic and behavioristic counselors look for changes in behavior based on new insights. The behaviorists go so far as to assign homework so that new skills are taught. On the other hand, the psychoanalytic counselors offer action in the form of expression of repressed emotions by the clients. How reorganization takes place in this theory is unclear. It is assumed that when emotional patterns are uncovered that insight alone causes

positive changes, which in the case of bereavement would be reorganization. This observation that psychoanalytic grief counseling theory is an insight psychology and that behavioristic grief counseling theory is an action psychology is, of course, true of the theories in general and is not just limited to grief counseling (London, 1964).

Techniques for Grief Counseling

Where techniques for counseling are concerned (Table 10), it could be said that most of the therapists studied herein, with the notable exception of Freud, are willing to use any technique which works well for their client (Parkes, 1972; Severin, 1967; Ramsay, 1979). Theorists from each framework have contributed techniques. Many techniques are suggested by proponents of more than one theory. For example, "linking objects" are suggested by both the psychoanalytic school and the behaviorists. Similarly, Gestalt techniques have been used by humanists, behaviorists (Ramsay, 1979), and psychoanalysts (Parkes, 1972).

All theorists advise against the long-term use of drugs to treat grief. They argue that drugs inhibit the grieving process (Parkes, 1972). Additionally, the risk of alcohol addition sharply rises during the first year of bereavement (Marris, 1958; Parkes, 1972; Bowlby, 1980).

Transference is discussed by many psychoanalysts and by a behaviorist, Ramsay. Both groups acknowledge that the phenomenon of transference does exist, but they differ in

Table 10

Summary of Techniques

Psychoanalytic theory	Humanistic theory	Behavioristic theory
1. Transference (Lindemann, 1944; Freud, 1916/1957; DeLeon Jones, 1979; McCann, 1974; Altshul, 1963)	1. Any technique which encourages spontaneity, courage & creativity (Severin, 1967)	1. Transference (Ramsay, 1976)
2. Drugs-disputed issues: Lindemann (1944) temporary use; Parkes (1972) do not use. Merely postpones grief. Risk of alcohol addiction (Marris, 1958; Parkes, 1972; Bowlby, 1980)	2. Religion (Frankl, 1967)	2. Humanistic techniques (Ramsay, 1977b)
3. Safe Place, safe objects and safe situations (Glick et al., 1974)	3. Counselor as role model (Frankl, 1978)	3. Flooding on selected clients (Ramsay, 1976)
4. Linking objects (Glick et al., 1974; Bowlby, 1980)	4. Gestalt Techniques	4. Linking Objects (Ramsay, 1979)
5. Community help (Parkes, 1972)	5. Finding meaning in all situations (Frankl, 1967)	

how it should be treated. Those from the psychoanalytic school regard transference as a useful tool in releasing repressed emotions (Freud, 1916/1957). In other words, the clients can express their ambivalence toward the deceased by transferring those feelings to the therapist.

Ramsay (1976) acknowledges the existence of transference, but he declines to use it as a tool for insight. For Ramsay (1979) to take time for the clients to gain insight as to why they feel the way they do about their therapists is a waste of time. The fact that the clients are able to experience emotions, albeit misdirected emotions, is in itself a therapeutic release.

Some techniques for counseling the bereaved spouse are unique to an individual counselor or a theoretical framework. For example, Ramsay (1976) has used flooding with carefully selected patients. His rationale for using flooding is based on the assumption that abnormal grief develops as phobias do (Eysenck, 1967) from an attempt to avoid a painful situation. Since the etiology of phobias and abnormal bereavement are the same, Ramsay (1979) has adapted a flooding technique used in phobias to the treatment of abnormal grieving.

An example of an emphasis unique to some humanists is the use of religion as a means of understanding a universal plan (Frankl, 1967).

Criticism

All theories have been criticized for producing too little literature to further the study of the grieving process (Table 11). During the last ten years, this situation has been somewhat improved due to the effort of many of the theorists discussed within the context of this dissertation. There is a call in general for new research based on strong scientific studies.

Much of the criticism of Freud's views on such concepts as the "death instinct" will never be resolved. The value of the "death instinct" and the concept of "Libidinal energy" is that they are starting places for the study of the larger topic of the problems of grieving people.

The criticism of grief counseling theory is sparse. In general, it advocates a creative study of the general topic of loss.

Implications for Counseling

Several implications from this study can be applied by the counselor to help grieving clients. First of all, counselors must recognize that a person who has experienced a loss does not necessarily need counseling. In fact, in depth psychoanalysis or Ramsay's flooding technique would actually be harmful for the client (Freud, 1909/1963; Ramsay, 1979) within the first year of bereavement. If a

Table 11

Criticism of Grief Counseling

Psychoanalytic theory	Humanistic theory	Behavioristic theory
1. Criticism of Freud use of abnormal population (Bowlby, 1961) vague concept of libidinal energy (Glick et al., 1974) concept of death instinct unclear	1. Vagueness (Child, 1973) 2. No scientific validation (Child, 1973) 3. Frankl criticized for emphasis on the importance of God. This is considered non-scientific (Wilson, 1972; Child, 1973)	1. Literature does not fully deal with problems of the grieving client (Franks & Wilson, 1976; Ramsay, 1976) 2. Ramsay's (1979) therapy too draining for some therapists (Ramsay, 1979)
2. Too time consuming (Ramsay, 1976, 1977)		3. Ramsay's therapy good for only a limited number of clients (Ramsay, 1979)
3. Lindemann's work (1944) oversimplification and no follow-up (Solomon, 1977)		4. Walden II by Skinner (1948) is impractical
4. Straying from psychoanalytic theory (Criticism of Bowlby (Parkes, 1974)		

client comes to a counselor shortly after the death of a loved one, the counselor could offer a supportive, empathic therapy (Rogers, 1951; Ramsay, 1979). Group therapy might be especially useful (Parkes, 1972; Bowlby, 1980). However, an emotionally stable client who has a supportive family and/or friends should not need the help of the therapist unless the death occurred under unusual or violent circumstances. Unfortunately, the bereaved clients who seek help from the grief counselor have usually been unable to find anyone to talk to about their loss, hence they look for outside help.

Clients who come to the grief counselor should be informed that the goal of the counselor will not be to lessen the pain associated with their loss. Instead, the function of the counselor in the first year of bereavement is to offer emotional support to the clients so that they may experience their pain. Pain is a necessary part of the grieving process and attempting to alleviate or to suppress the pain of loss only prolongs the grieving process and may inevitably lead to abnormal grieving (Frankl, 1971; Freud, 1917/1957; Ramsay, 1979). Some counselors mistakenly try to make their clients feel better by encouraging new activities, a change in residence, or a new loved one too soon after the loss. These activities, performed within the first 6 months to 1 year after a loss are usually means of avoiding grief work. Clients themselves will decide when

they are ready to make changes. This usually occurs at one year after the death of a spouse (Glick et al., 1974). This approach to grief counseling, one of not trying to immediately lessen pain, is sometimes difficult for the therapist. Most therapists like to see improvement as soon as possible. This does not occur in grief counseling. Grieving clients often feel worse before they feel better. If, however, therapists understand the grieving process as it has been defined through research (see Chapter II), then they will be able to see hope for the client. The therapist will know in time the pain will lessen. Ordinarily the clients will heal themselves if grieving is progressing in a normal fashion. The therapist who has hope for the clients' futures will be able to convey that element to the client. Hope for the future is the main ingredient of the grief counseling which occurs during the first year of bereavement (Frankl, 1975).

The grief therapist knows that "grief work" is really "work". It is a difficult process which must be completed before reorganization can begin. It is as if grief were a stack of hay which has to be moved to another place. Each fork of hay is laden with memories which must be picked up, reviewed, and set down again. When the entire hay stack is moved, then life can begin again. Unfortunately, there is no way to move the hay other than enduring the pain of moving it. Grief is an emotional task rather

than the physical one of moving hay, but the concept remains the same.

During the first year of bereavement, the counselor often assumes the role of educator. Grieving people sometimes need to be assured that their strong emotional reactions are normal. Sometimes they feel that they are losing their minds, especially when they think that they see their deceased loved ones in familiar places. The phenomenon of grief can be a terrifying ordeal for a person who does not know that is normally experienced.

The grieving clients who come to the therapist must be asked some questions to determine if they are likely to grieve in an abnormal way. Whereas the counselor can encourage a normal client to find support from family and friends, a person who is likely to grieve abnormally should receive professional counseling soon after the loss. Clinical interventions with these clients has been shown to be effective in preventing abnormal grief (Bowlby, 1980). What are the predictors of abnormal grief? Current researchers are studying these questions (Vachon, 1982; Raphael, 1977). Although abnormal grief predictors have not been discussed in detail in this dissertation, it has been said that, in general, the past behavior is the best predictor of future behavior (Carkhuff, 1967). So, clients should be asked about how they handled their prior losses. If their primary means of coping with loss is avoidance, they may grieve

abnormally. According to Freud (1917/1957), only people who had underlying personality problems developed melancholia (abnormal grief reaction).

Other indicators of abnormal grief appear soon after a loss. If the bereaved person still denies the loss after several weeks (Glick et al., 1974) or even believes that the deceased person is actually present (Ramsay, 1976), abnormal grieving may be expected. It is generally agreed that excessive anger and/or guilt are common features of abnormal grief. The therapist has to make a professional judgment as to how much anger or guilt are excessive since they frequently occur in a lesser degree in normal grief. It can be said that in normal grief, anger and guilt are not the most prominent features. Sadness and mild depression emerge as the main feature in normal grief. In abnormal grief, anger and/or guilt are the most prominent features. Sometimes the client is so overwhelmed by guilt or anger that "grief work" cannot progress.

During the first year after a loss, even if factors indicate that a client is predisposed to grieve abnormally, the choice for treatment is a supportive empathic approach (Ramsay, 1979). There may be a few exceptions to this rule in cases where the person is clearly exhibiting pathology. For example, a client may be unable to function for months after the death or, as in Ramsay's case study (1976), a client may totally deny the loss months after the event.

This conservative approach in choosing a treatment is always recommended (Freud, 1917/1957; Ramsay, 1979) because of the tendency of the pain of grief to dissipate on its own with time and because it is difficult to evaluate the psychological stability of a person who has recently suffered a loss. For example, often grieving people receive scores on the MMPI which indicate that they are very ill. These scores fall back with a normal range about a year (Ramsay, 1979).

What then are the components of this supportive therapy? Table 9 has shown the grief counseling process. It can be seen from this table that all three theories offer the elements of a supportive therapy. That is, they all begin with the same two supportive steps: (1) the importance of the counselor-client relationship and, (2) the review of the details of the death, before and after. These two steps serve the function of providing an accepting atmosphere in which emotions can be expressed. In the psychoanalytic view, emotional expression allows hypercathexis (Freud, 1917/1957), a feeling of libidinal energy so that it may be redirected toward other interest or loved ones. Humanists review the details of a loss to find meaning in the suffering. Behaviorists view emotional expression as being necessary for extinction. Whatever the mechanism of change, any of these three theories can provide help for the client in the first year of bereavement.

As the client progresses, near the end of the first year, action and reorganization (general concept 5, Table 9) will usually occur. For psychoanalysts, the expression of anger is a signal that active grief is ending. Humanists and behaviorists stress growth that comes from learning how to deal with tragedy. So, at about the one year point, the grief counselor should be able to terminate the sessions or at least decrease the frequency of the counseling sessions.

After one year it is generally agreed that the survivor should feel at least somewhat improved. If not, counseling is recommended. After this one year period, the therapist needs to take additional steps to facilitate grief. Looking again at Table 12, an adaptation of Table 9, it can be seen that steps 3 where the therapist insists on the reality of the death and step 4 where the therapist searches for patterns may be used. Here again, theorists from the three frameworks have different ways of approaching these steps. Points 3 and 4 are a necessary part of counseling people who are grieving abnormally because these clients usually try to avoid the pain of grief by denying their losses. People who grieve normally do engage in some denial, but over a period of time, the reality of the loss is accepted. Although the therapist who treats the grieving client during the firs year of bereavement does not allow the clients to delude themselves into thinking that the dead person will return, the therapist does allow for some denial

Table 12

Relationship Between the Counseling Process for Clients Grieving Normally and Those Grieving Abnormally

	General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory
Normal	Step 1 Importance of counselor-client relationship	Therapist emphathic and open to client's loss (Corazzini, 1980)	Therapeutic relationship essential to change (Rogers, 1951)	Establish relationship (Ramsay, 1979)
Normal	Step 2 Review of details of death, before & after	Hypercathexis (Freud, 1916/1957). Client talks freely about events surrounding death (Parkes, 1972; Bowlby, 1980)	Client relates loss. Therapist helps client to find meaning in suffering. All details need not be included (Frankl, 1978)	Review of details of death (Ramsay, 1979)

Table 12 (continued)

General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory
Step 3 Therapist insists on reality	Insist on reality of death (Corazzini, 1980; Parkes, 1872)		Force realistic view of death (Ramsay, 1976). Identify faulty thinking patterns (Rush & Beck, 1978)
Step 4 Search for Patterns	Search for origin of feelings--review of past losses (Freud, 1916/1957)	Client explores attitudes to find non-useful patterns. Insights gained. (May, 1975)	Analyze faulty thinking for unhealthy patterns (Rush & Beck, 1978)
[AFTER APPROXIMATELY ONE YEAR, STEPS 3 AND 4 ARE USED]			

Abnormal

Table 12 (continued)

General Concept	Psychoanalytic theory	Humanistic theory	Behavioristic theory
Step 5 Action and Reorganization	Expression of repressed emotions, especially anger and guilt (Parkes, 1974). Other action not specified.	Clients act on new insight (May, 1975)	Skills are learned so that regression does not take place. Action Practice assignments learn how to solve problems (Rush & Beck, 1978)

Normal

especially in the phase of yearning and searching. In this phase the client actively looks for the deceased person. In contrast, in the second year of bereavement, the therapist will probably need to insist on the loss (step 3). This insistence must be done carefully. Warnings related to Ramsay's (1979) behavioristic approach must be considered.

Step 4, searching for patterns, must be used with clients who are still actively grieving after one year because some abnormal attitudes or faulty thinking are probably blocking the resolution of their grief. Psychoanalysts look to the past (Freud, 1917/1957). In this framework, current losses are somehow related to feelings provoked by earlier losses. Humanists explore attitudes to find non-useful patterns. Behaviorists take a cognitive approach and analyze faulty thinking for unhealthy patterns (Beck, 1977; Rush & Beck, 1978). In short, some faulty patterns have developed. These patterns need to be isolated, analyzed, and corrected. When a client has corrected these faulty patterns (step 4) (and has admitted the reality of the loss (step 3)) then the therapist can help the client reorganize (step 5).

To summarize, a therapist using any of the three theoretical frameworks may counsel a bereaved person. During the first year of bereavement, except in a few severe cases, whether the client is predisposed to abnormal grief or not, the following three steps from Table 12 are used for

counseling: (1) establish a counselor-client relationship, (2) review of the details of death, before and after and (5) action and reorganization. After about one year from the date of loss, if grief is still active and appears abnormal, then the entire grief counseling process from Table 12 should be used.

Aside from suggesting procedures for counseling people who are grieving both in abnormal and normal ways, this dissertation offers additional implications for counselors. One of these implications concerns the problem of recognizing an abnormal grief reaction. Many times, unresolved grief issues do not emerge for years after the loss. A client may go to a therapist with a presenting problem unrelated to loss. Because many clients and some therapists do not recognize the problems which can be caused by not dealing with a loss, they sometimes fail to recognize the unresolved grief as being at the root of their problems. It is proposed here that despite the presenting problem, therapists must <u>always</u> ask clients about their major losses. The therapist must know who has died in the client's life. The therapist needs to know how the client grieved. If it was not a normal reaction, unresolved grief is probably a contributing factor to the current problem.

Another side of this problem is that a client may be suffering from anticipatory grief (Lindemann, 1944) and not recognize it as a problem. The therapist must also ask if

anyone in the family, or the client themselves, is likely to suffer a loss or has a serious illness. For example, a client might come to a therapist for problems related to anger. It was discovered that the client's anger was related to a feeling of helplessness over a parent's impending death.

It can also be inferred from this literature that only counselors who can deal with topics related to death can be grief counselors. Every theorist cited in this study who has counseled bereaved people has stressed the importance of emotional expression and review of painful events as a necessary part of grief therapy (Freud, 1917/1957; Glick et al., 1974; Frankl, 1979; Ramsay, 1976, 1979; Bowlby, 1980). Ramsay warns that flooding therapy can be done by only a few, experienced, emotionally strong therapists. Of course, these therapists must not only be able to listen to the grief of others, but they must have faced their own grief issues (Carkhuff, 1977). Hearing about the tragedies of others triggers memories of personal losses for the therapist. This fact makes this a difficult type of therapy for many counselors (Ramsay, 1979).

Finally, this dissertation points out the need for a new leadership role for counselors in the area of prevention of abnormal grief--the counselor as teacher. For most people, grief counseling would not be necessary if they were provided with adequate death education and emotional support

(Skinner, 1948; Glick et al., 1974). For reasons previously discussed, when someone dies, the survivors are discouraged from expression of their grief. Counselors need to educate the public on several points including the characteristics of normal grief and the importance of talking about feelings and the circumstances of the loss. People need to be educated as to how they can help their bereaved friends and loved ones.

Implications for Further Studies

Several additional research studies are recommended as follows:

1. A survey of grief counseling practitioners could be done to determine their theoretical frameworks and how they combine techniques, process, etc. This research could be aimed at evaluating the feasibility of combining the three theoretical frameworks (Bruce, 1984). The question to be examined in this research would be, "Can a grief counselor who is from one school of thought use information from another theoretical school?" For example, is it acceptable for a behaviorist to use the psychoanalytic work on the characteristics of the grieving spouse? Is it acceptable for a psychoanalytic theorist to use a Gestalt technique? It is suggested herein that knowledge from one theory may be transferred to another as long as the counselors do not lose sight of their own views on the nature of man and their own personal spontaneity (Patterson, 1966). "Each theory has

its place in helping counselors conceptualize an appropriate understanding and process for each of a variety of clients and situations" (Bruce, 1984, p. 259).

2. Longitudinal studies of the grieving spouse three and four years after the bereavement are indicated. The purpose of these studies would be to ascertain if most grief is actually resolved after two years or if the time limitation of the current research has limited the accepted time frame for active grieving. These studies could be similar to Bowlby's (1980) work with children and adolescents during the third and fourth years after a loss.

3. Further research exploring the relationship, if any, between the loss of a spouse and the onset of cancer is recommended. Preliminary research indicates a possible strong correlation (Jackson, 1962; Shealy, 1977).

4. Research to explore the possible use of systematic desensitization with the grieving client is recommended (Ramsay, 1977b).

5. Historical and experimental research to explore the relationship between depression and bereavement might be worthwhile.

6. Experimental research could be done to evaluate if any framework is more effective with certain clients than with others. It is possible that people who are in physical pain may respond to a different type of counseling than people who survive the loss of a loved one. The assumption here is that physical pain is a different, more intimate, type of loss.

7. Psycho-biographical research could be done to analyze how the personal events and personalities of the psychologists discussed in this dissertation affected their attitudes and theories about grief. For example, from the above discussion, it can be seen that the death of a loved one, Freud's father and Skinner's brother, was a common experience shared by Freud and Skinner. Yet, their reactions to these losses were quite different. Skinner was able to look on objectively, while Freud began an emotional search into his relationship with his deceased father. One could speculate that Skinner had found the death of his brother so painful that he was unable to deal with his emotions, so he denied them. Yet, this position is not substantiated by the research on Skinner presented in Chapter IV of this study. Skinner is now 79 years old, physically able, and mentally alert (Langone, 1983; Skinner, 1983). He has led a productive life and is a "warm, kindly, and sentimental" (Langone, 1983, p. 38) person. This

example substantiates Shand's (1920) early idea that grief is an emotion expressed uniquely according to the personality of the survivor.

Undoubtedly, the philosophies of these theorists and all the other writers discussed in this dissertation were affected by their personal experience. Exploring the relationship between the men and their works could be enlightening.

Grief counseling has begun to be a frequent topic for study only in recent years. Many questions are left unanswered. A few of these questions have been listed in this dissertation, but these suggestions represent only a few of possible directions which researchers may take. Because the study of grieving people is a relatively untrodden area, research in this area is of particular importance.

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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